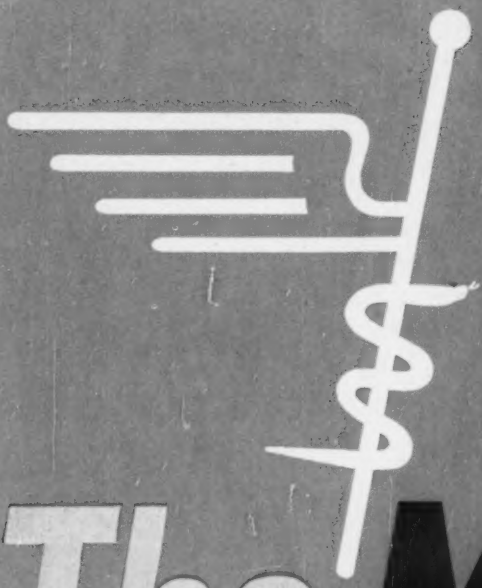
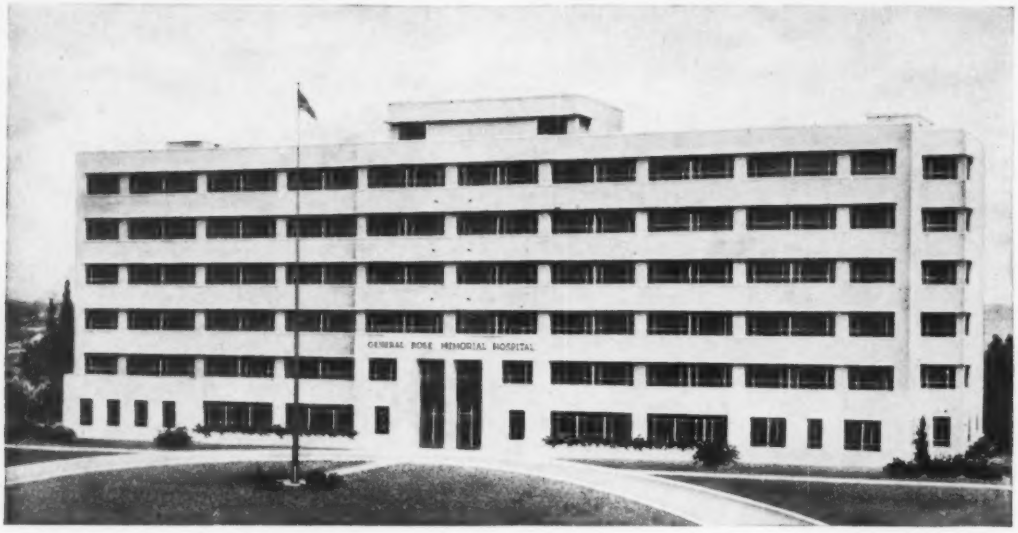


The Modern Hospital

FEBRUARY 1950

They made their own hospital • *The voluntary hospital system can survive the truth* • *Don't lock up psychiatric patients* • *Food service in veterans' hospitals* *Floor secretaries relieve the nurse* • *In defense of Appendix A*

ANOTHER BUILDING OF PROMINENCE SLOAN EQUIPPED



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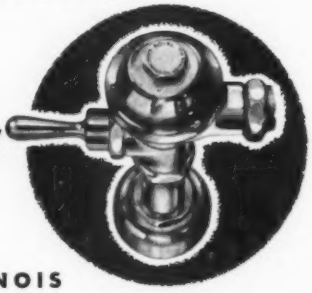

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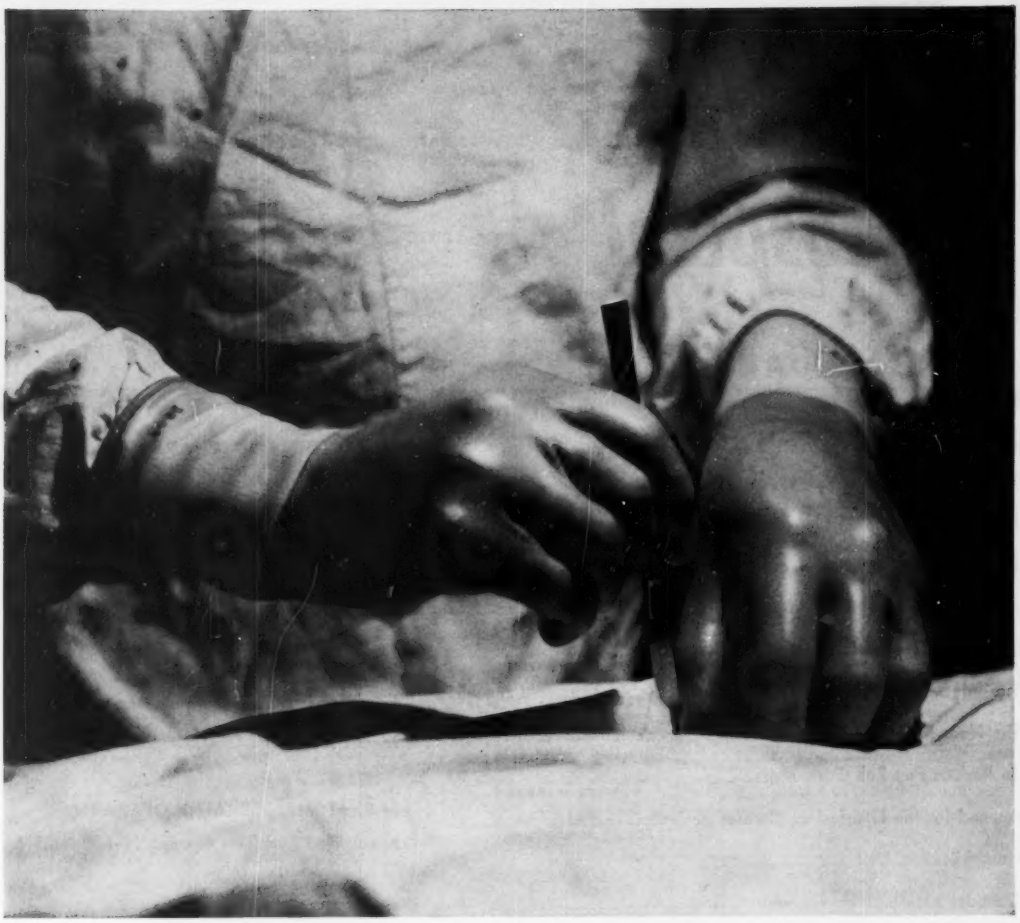

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Surgeons' Gloves

The Modern Hospital

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FEBRUARY 1950

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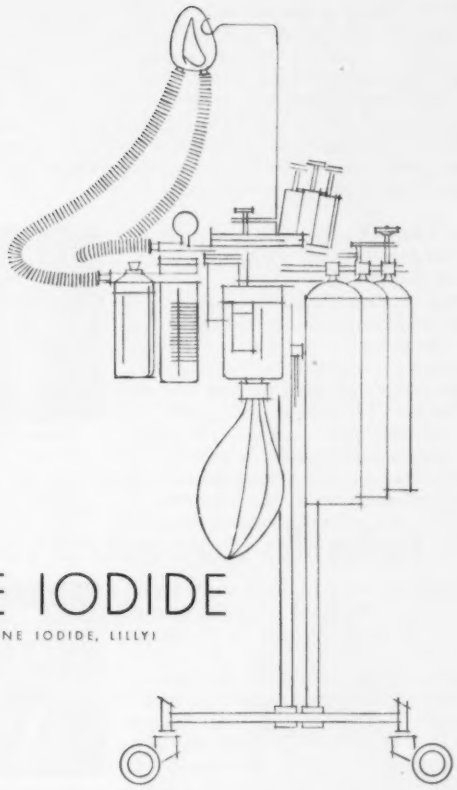

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AMONG THE AUTHORS

When he isn't flying to Iran or Africa or somewhere on an investigative mission for the government, **Karl Detzer** is likely to be flying to Maine or California or somewhere on a reportorial mission for the *Reader's Digest*. A roving editor on the *Digest* staff since 1939, he took time out to serve in World War II as a colonel on the General Staff Corps. Following World War I he was an officer in the Division of Criminal Investigation—America's secret police in Europe. This experience was the subject of his first book; later books and screen plays he has written also show a strong bias for investigation and adventure. Between flying trips to various remote parts of the world, Mr. Detzer publishes a newspaper and investigates trout streams near his home town of Leland, Mich. His trip to near-by Ely, Minn., to investigate the Ely-Winton Hospital there (see page 43) was notable for many reasons: Among other things, it was the first time he had been on a train for years.


Geneva Katz

Geneva Katz, R.N., is assistant director of the Boston Floating Hospital, the pediatric unit of the New England Medical Center, in Boston. Her story on page 65 describes a product of her own fertile imagination backed by technical knowledge and skill. Miss Katz's professional experience began with operating room staff nursing immediately after her graduation from the Ellis Hospital, Schenectady, N.Y., where she became operating room supervisor. Her professional career was interrupted by a period of study at Boston University, where she majored in business administration and was graduated in the school of education. Miss Katz came to her present position after three years as assistant administrator of the Waltham, Mass., Hospital.


Lawrence Brett

Lawrence Brett, whose article on small hospital budgets appears on page 70, is administrator of Lexington Memorial Hospital at Lexington, N.C., where he went a year ago after getting his master's degree in hospital administration at Northwestern University and serving an administrative internship at Watts Hospital, Durham, N.C. A native North Carolinian, Mr. Brett was graduated in business administration at Duke University, then worked for Blue Cross until the navy beckoned. He spent several years as a deck and division officer in gunnery, mostly at sea; following his discharge he entered the hospital field as office manager of the Grace Hospital at Morganton, N.C.


A. W. Smith

A. W. Smith, who is rapidly indoctrinating Summit, N.J., in the practices and problems of its community hospital (see page 80), has been in health and hospital administration for twenty-five years—first as a young clerk and bookkeeper in the Toronto, Ont., Department of Public Health, then in the business offices of the Riverdale Isolation Hospital at Toronto and, later, the Royal Victoria Hospital at Montreal. He was assistant superintendent of the Royal Victoria for seven years before he went to Summit's Overlook Hospital as administrator in 1947. Active in his local, state and national hospital and public health associations, Mr. Smith has contributed a number of articles on personnel, purchasing and accounting subjects to the Canadian hospital magazine.

reduce postoperative morbidity with intravenous alcohol

Quiet, restful sleep following surgery may be easily induced by the use of intravenous alcohol as a sedative and analgesic.[1] Cough, gas pains, urinary retention, vomiting, and fever are materially reduced when alcohol is used to decrease or eliminate the use of morphine.[2,3]

Since alcohol is a food as well as a drug, it is almost completely metabolized. In addition to the sedative and analgesic qualities, one liter of 5% Alcohol, 5% Dextrose solution furnishes 475 calories. When properly administered, undesirable side effects are rarely encountered.

Alcohol is the sedative and analgesic agent in the following:

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GENERAL OFFICES • EVANSTON, ILLINOIS

Reader Opinion

Hospital Planning Conference

Sirs:

While the proposed staff hospital for the University of Illinois (presented in the January 1950 issue of The MODERN HOSPITAL by Dr. A. C. Ivy and William H. Binford) was in preparation in the architects' offices, a group of experts in various phases of hospital administration was called together to review and criticize tentative plans. Members of the panel, in addition to the architect, were: Dr. Robert F. Brown, medical director of St. Luke's Hospital, Chicago; Ray Brown, superintendent of the University of Chicago Clinics; Elizabeth Odell, R.N., director of the Evanston Hospital School of Nursing, and the writer.

Discussions of the group brought out a number of things about the original plan that needed change or adjustment, and such changes were made before the final plans were drawn and published. This experience underlines the importance of having the advice of operating administrative, medical and nursing executives in connection with hospital planning. Too often, plans not submitted to such critical scrutiny get into final production, or even actual construction, before glaring weaknesses are revealed—obviously an extravagant reversal of logical procedure.

In the present instance, some of the comments of the panel members, while not acted upon by the architects, were on debatable points of interest to all who are planning hospitals today. A brief review of these points, as summarized in a report of the discussions, is presented here:

Dr. Brown pointed out that there are probably too many different entrances, which would result in problems of control. He suggested that there is no particular reason for the extra nurses' entrance and that they should come in the regular employes' entrance. This led to a discussion of whether or not it is feasible to put nurses on a time clock, and the general agreement that if it is feasible to put nurses on a time clock, all employes should come in one entrance for control through the time-clock area.

In discussing the basement plan, it was pointed out that it is bad practice to have to take the cans of garbage directly through the receiving corridor where clean food is coming in, and it was suggested that a new arrangement be worked out in this receiving corridor so that garbage could come into the refrigerated garbage room directly from the kitchen. Comment was made that if possible it would be nice to combine the can-washing and the refrigerated garbage area on one side of the receiving entrance to provide a little more space and flexibility in the receiving entrance corridor at the kitchen end.

In considering the plan for the first floor, members of the panel agreed that the private office of the combination business and credit manager should be immediately adjacent to the admitting office and the cashiering setup. It was also agreed that this hospital is large enough to require an assistant administrator, and that the most desirable

arrangement of space would be for the administrator's and assistant administrator's private offices to open into a common secretarial office and waiting room. This arrangement, members acknowledged, provides an ideal environment for coordinated operation of the administrative offices.

Also, it was the general opinion that there should be a small, adjunct waiting room to serve the admitting office and credit manager area. The general opinion was that there was not enough admitting office space, and there should probably be a minimum of two admitting offices, or one admitting office with a series of two or three private cubicles for interviews.

Miss Odell brought up the point that there is not enough space for the administrative organization in the nursing department. She felt that an absolute minimum would be a private office for the director of nursing service, a secretarial office combined with a small waiting room, and another office area partitioned into possibly three cubicles for assistants. Members of the panel rejected a suggestion that there be any small cubicles for assistants to the director of nurses, and Miss Odell said that she wasn't worried about the amount of space for these assistants but she was certain that they should have small private office areas.

Mr. Jones brought up the point that in a hospital like this a small gift shop and soda fountain are a great convenience not only for visitors but also for employes and doctors, and may also be an excellent revenue producer for the hospital. This type of facility should probably be in the main administrative area where it can be seen by everybody coming into the hospital and from the waiting room, it was suggested. Although the panel was in substantial agreement that a small gift shop and soda fountain are fine things and a convenience to everybody concerned, it was pointed out that there are some dangers inherent in the possibility of wastage of time by employes who would spend too much time in such an area, and this should be carefully considered.

Miss Odell pointed out that there seemed to be a lack of central utility work units for the doctors' offices, and there seemed to be no provision for the storage of miscellaneous equipment, treatment trays, and so on which are bound to be called for in an office setup like this. Mr. Brown raised the point that the offices did not seem to be laid out so as to accommodate the needs of various specialists, for example, the ear, nose and throat men and the dermatologists would probably need somewhat different arrangements than those shown. Suggestion was made that those responsible for this program should give a clear cut list of what specialists would be practicing in these offices so that a little more attention could be paid to office space to meet their special requirements.

In connection with the geriatric units on the second and third floors, all members of the panel were in general agreement that there was insufficient storage space for wheelchairs unless folding chairs were used exclusively. Members of the panel seemed to feel that some additional provision must be made for diversional and occupational therapy facilities, and that there certainly must be provision for a patients' library, because many of these old people will do a lot of reading.

Everett W. Jones

Indigent Payments

Sirs:

The board of trustees of the Presbyterian Hospital and board members of

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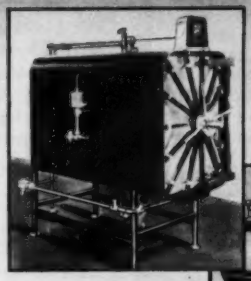

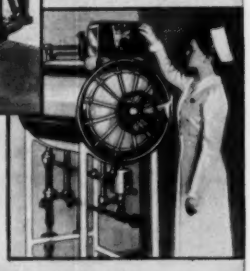

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other hospitals in this state have made a conscientious effort not only to tell their story to the duly elected officials but also to obtain for hospitals a large increase in appropriation.

The Hospital Council of Allegheny County in anticipation of the state legislature setting the appropriation figure for the hospitals for the biennium 1949-1950 arranged a luncheon meeting at one of the local hotels to which it invited state representatives from this district. At that time facts and figures were given to these gentlemen concerning the cost of hospital care and the cost of care given to indigent patients, along with other pertinent information, in an effort to obtain the sympathy and interest of these men in this matter to give the hospitals some relief. This action was followed up by the Pennsylvania State Hospital Association appointing a special committee representing the hospitals of the state to call on the governor and the appropriation committee of the state legislature. This committee followed through its assignment and did everything humanly possible for the institutions of this commonwealth to obtain for them a substantial increase in their grant. I fully appreciate the fact that in writing this letter I cannot sufficiently emphasize the effort that the hospital superintendents and members of their boards put forth along this line.

A few facts and figures concerning the Presbyterian Hospital appropriation will be more or less indicative of the accomplishment of the hospitals of this state with reference to their appropriation. For the past several years the appropriation to the Presbyterian Hospital was $82,000 per biennium. For the biennium 1949-1950 the Presbyterian Hospital requested an appropriation of $363,000. This figure was estimated by multiplying the anticipated free days for the biennium by the ward cost per patient day. While our accounting procedure is not exactly that which is followed in the government reimbursable cost formula, it approximates it sufficiently and, if anything, is somewhat lower than the government formula would give. The commonwealth came through with an appropriation to the Presbyterian Hospital of $98,000—an increase of $8000 per year.

The difference between what the commonwealth provides ($98,000) and what this cost is to the Presbyterian Hospital ($363,000) is indicative of the needs of the institutions of this state for additional financial support from their city, county and/or state government.

It appears to me that over a period of many years hospitals and their representatives have made a sincere effort to enlighten the legislative bodies concerning their predicament. As can be noted, a great deal of progress has not been made. As a matter of fact, it would appear that this business of petitioning the legislature is equivalent to butting one's head against a stone wall. Possibly the state hospital association should submit facts and figures to all of the newspapers along with an ultimatum to the effect that as of a certain date they would be happy to care for the indigent of the community to the extent of their appropriation from the state, but beyond that point they would not be able to go. If that were done, the people of the commonwealth might become so concerned or alarmed that they would petition their representatives to do something along the lines of cost for the hospitals of the commonwealth. Of course, the procedure just outlined might have many repercussions, and I am not sure that it would be the proper action to take. However, I am quite certain that some definite approach will have to be found in order for the hospitals to gain their objective.

Thompson D. McCrossin
Superintendent
Presbyterian Hospital
Pittsburgh

Not Much Difference

Sirs:

Ray Brown's article ("Hospital Tensions Threaten Tenure," The MODERN HOSPITAL, November 1949) interested me very much. I firmly believe that organizationally there is not very much difference between a hospital and an industrial or business enterprise. It is essential in both that the functions of the board and those of the executive be strictly separated; the importance of this cannot be emphasized and repeated too often.

This is particularly true of our small hospitals, and those of 100 beds and less constitute one-third of our hospitals. The administrators of these hospitals deserve and need as much help as we can give them, because they conduct their work often under the most trying circumstances. In all our considerations of hospitals, the needs of the small hospitals are far too often neglected.

Administrator
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palatable meals for your patients

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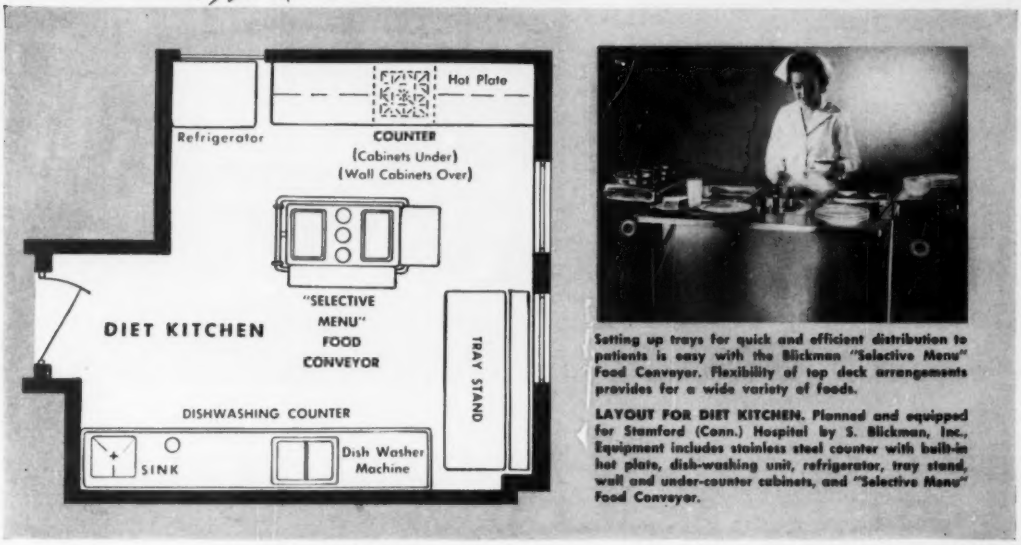

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LAYOUT FOR DIET KITCHEN. Planned and equipped for Stamford (Conn.) Hospital by S. Blickman, Inc., Equipment includes stainless steel counter with built-in hot plate, dish-washing unit, refrigerator, tray stand, wall and under-counter cabinets, and "Selective Menu" Food Conveyor.

• The importance of serving palatable, kitchen-fresh food to patients cannot be over-estimated in terms of patient morale, hospital reputation and the elimination of food waste. When you consider how much of your hospital's dollar goes toward food, its preparation and serving, the method of its distribution becomes of paramount significance.

Good technic avoids central tray service. This method requires the setting up of individual portions in the central kitchen. By the time the patient is served, he gets dried-out foods, cooled-off hot dishes, congealed gravies, softened butter and ice cream. Improved practice employs "Selective Menu" Food Conveyors, which transport food in hot bulk form, from central to diet kitchens. There the conveyor is set up as a serving station. Food is distributed, with a minimum of time and effort, and the patient gets it still fresh and appetizing.

The Blickman-Built "Selective Menu" Food Conveyor provides a variety of top deck arrangements to accommodate various menus. It is the only food conveyor made with *seamless, crevice-free top and body.* This improves sanitation, makes cleaning easy. Other features offer important advantages to efficient and economical procedures.

Now might be a good time to let Blickman hospital consultants assist you in planning your diet kitchens. For the experience which has proved of value to so many leading institutions, will prove of benefit to you, too.

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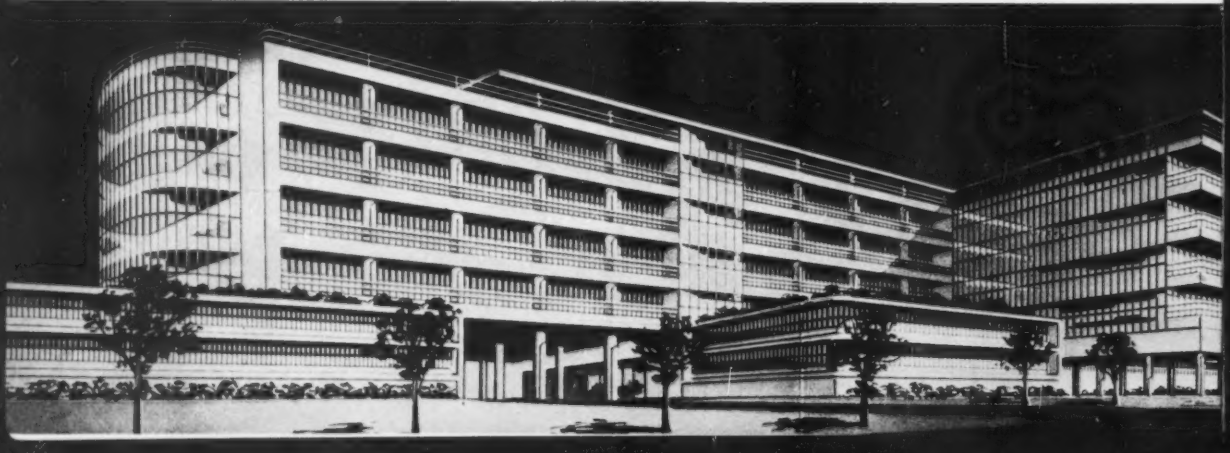

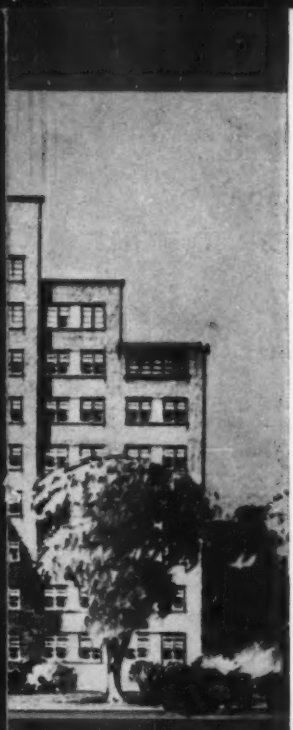

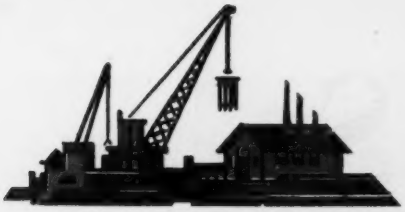

Never in its entire 125-year history has Syracuse seen a building as large as this new Veterans Hospital, now under construction by John A. Johnson & Sons, Inc. Also pictured below is the Veterans Hospital at Lebanon, Pa. This latter substantial contract has included the erection of several additional structures adjacent to the main hospital.

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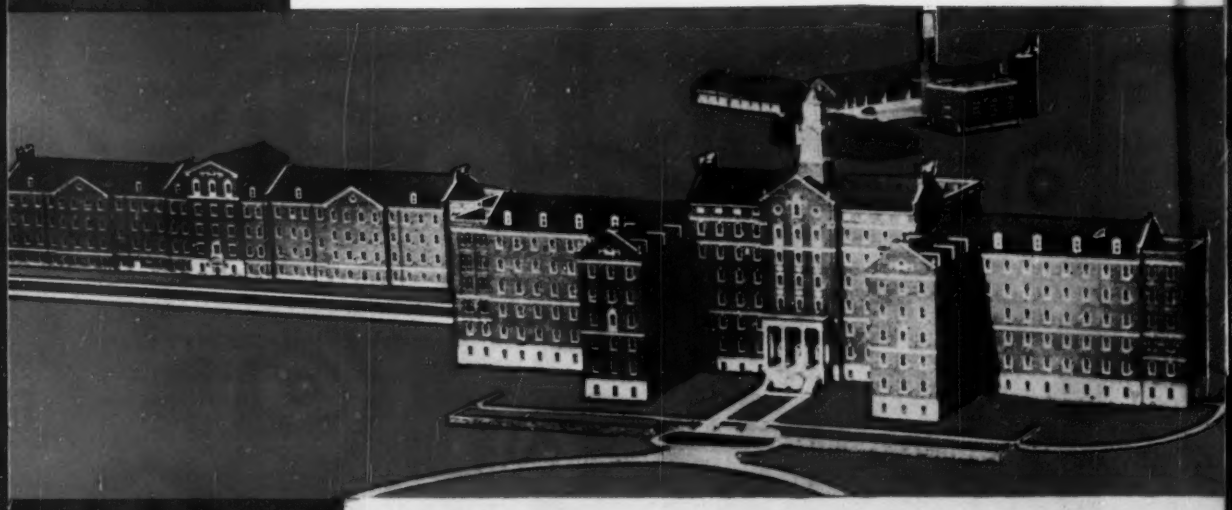

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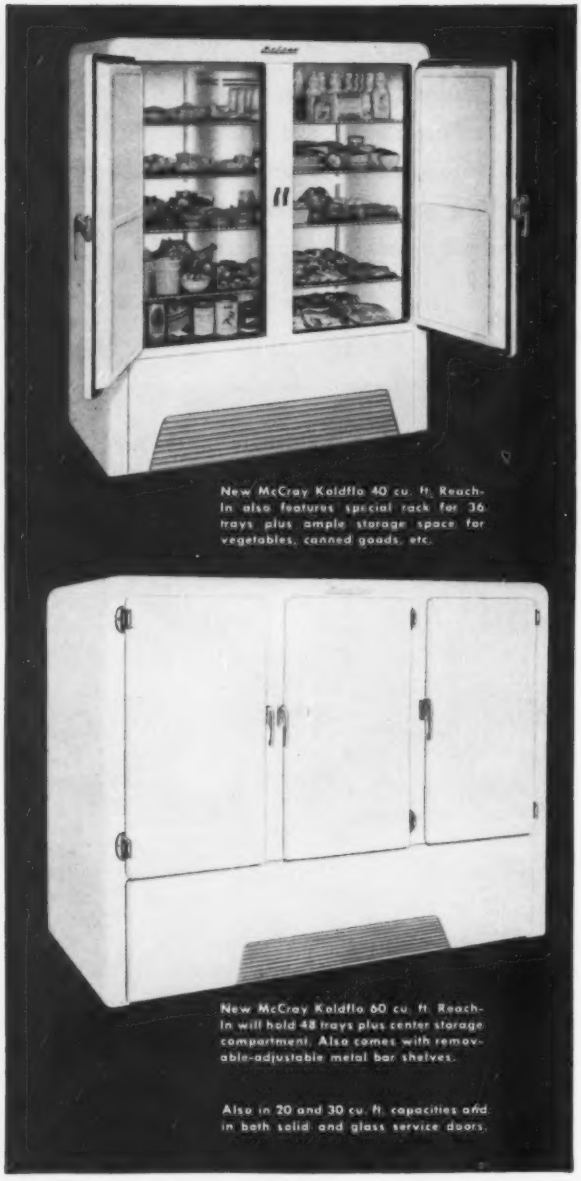

New McCray Koldflo 40 cu. ft. Reach-In also features special rack for 36 trays plus ample storage space for vegetables, canned goods, etc.

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Also in 20 and 30 cu. ft. capacities and in both solid and glass service doors.

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In countless commercial kitchens, the increasing volume of meals has so overtaxed facilities that much of the profit is lost in wasted effort, additional help and expanded floor area. An important solution to this problem has been to reorganize the kitchen around one or more McCray Koldflos.

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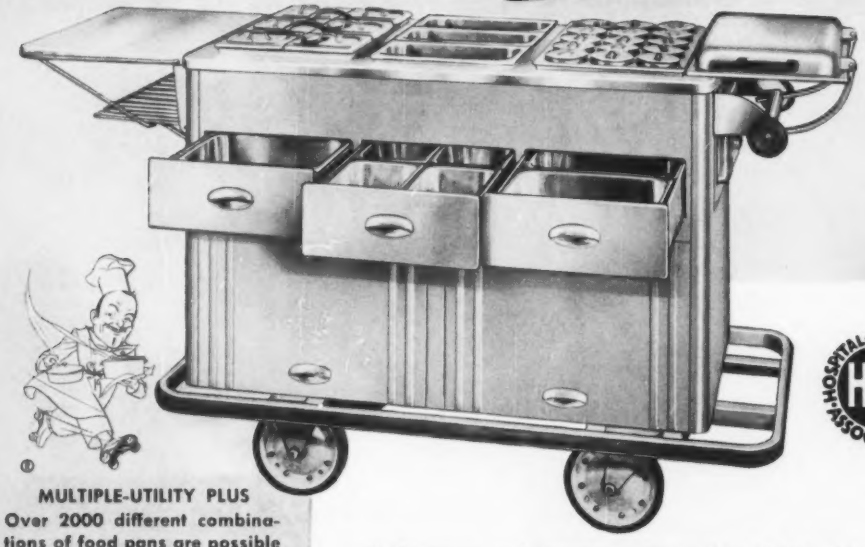

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MULTIPLE-UTILITY PLUS

Over 2000 different combinations of food pans are possible with this Ideal Unit. Each 12 x 20 inch well accommodates 1 full size pan, 2 half size, 3 third size, 4 one-fourth size or 6 one-sixth size. Pans may be 2, 4 or 6 inches deep. All pans are made of seamless Stainless Steel, with rounded corners for easy cleaning. Additional capacity is provided by three 12 x 20 inch heated drawers. Standard diet trays will fit both top deck wells and drawers.

A 16 inch shelf at one end folds down tightly to body. The well cover at the other end swings out to form another handy serving shelf.

Refinements and improvements in Ideal Food Conveyor Model 1003, enable this great labor-saving Ideal unit to render a still larger measure of service. Used for years by leading hospitals, this Ideal now gives you even more convenience and economy.

The food carrying capacity of Ideal Model 1003 is ample to meet practically any requirement, however large or varied. Three 12 x 20 inch wells in the top deck and three 12 x 20 inch heated drawers beneath them can carry a practically unlimited assortment and volume of food and maintain it at kitchen fresh temperature and savor.

Embodying all the patented design and construction features of the famous Ideal line this highly specialized Model 1003 is practically indestructible. Rigid, sag-proof top deck, easy handling and cleaning, ample safety, automatic control are designed and built into it as in all Ideal units.

Write for specification data on this and other Ideal conveyors, more than ever before in demand for meeting the more acute service and budget needs of today.

THE SWARTZBAUGH MFG. COMPANY
Established 1884 • Toledo 6, Ohio

Distributed by The Colson Corporation, Elyria, Ohio; The Colson Equipment and Supply Company, Los Angeles and San Francisco. *In Canada:* Canadian Fairbanks-Morse Company.

Ideal
FOOD CONVEYOR SYSTEMS
Found in Foremost Hospitals

Here's A Soup Service

THAT SOLVES EVERY SOUP PROBLEM!

1 Heinz Soups are made from the world's choicest ingredients, combined with homelike care and skill to produce the delicious flavors your customers *go for!*

2 Every one of the 12 kinds of Heinz Soups packed in 51-oz. tins has been carefully selected. According to a survey these 12 Heinz Varieties cover approximately 90% of the demand.

3 Heinz Soups in 51-oz. tins are easy to prepare and are ideal for fast, labor-saving service.

4 Heinz Soups in 51-oz. tins provide maximum convenience and enable you to serve without waste more kinds of soup than would otherwise be possible in the same place.

12 KINDS OF HEINZ SOUPS IN 51-OZ. TINS—Cream of Tomato • Bean Soup • Split Pea • Genuine Turtle • Cream of Green Pea Soup • Vegetable without Meat • Vegetable • Beef Noodle • Beef with Vegetable • Chicken Noodle • Chicken with Rice • Clam Chowder • Also Cream of Mushroom Soup in 29-oz. tins.

• Write for FREE recipe book, "Quality Recipes Using Heinz Condensed Soups." Address Hotel and Restaurant Division, H. J. Heinz Company, Pittsburgh 30, Pa.

57

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PURCHASING AGENT "Hospital equipment gets a lot of hard wear. But chip-proof, crack-proof Stanley products *just won't break*. Actually they pay for themselves in eliminated replacements."

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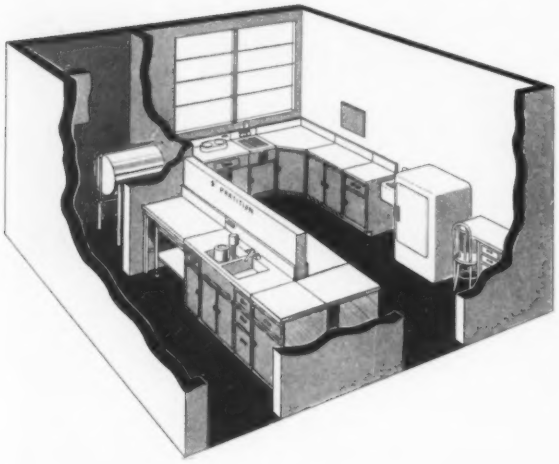
moduline

meets every hospital need



MILK FORMULA ROOM FOR A GENERAL HOSPITAL

EQUIPMENT LEGEND

GROUP 1 (FIXED)

1. 85L-24D—Drawer-Cupboard Unit without Splashback
1a. 85-L-24DSS—Drawer Cupboard Unit with Special-Depth Top
2. 85L-D35—Table Top Units with 85X-27 Legs (3 Prs. Required)
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6. 85L2238M—Milk Formula Sterilizer
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10. 85L-39—Corner Unit
11. Bulletin Board
12. 85L-35—Cupboard Unit
13. 85L-24D—Drawer-Cupboard Unit
14. Lavatory
18. 85ES-2—Electrical Duplex Plug Strip

GROUP 2 (NOT FIXED)

4. Olson Bottle Washer
7. 85P6398AL—Waste Receptacle-Silver lustre Finish
8. 85P5363—Double Element Hot Plate
15. Refrigerator
16. 85P6238—Nurses' Desk—Silver lustre Finish
17. 85P6327AL—Chair—Silver lustre Finish
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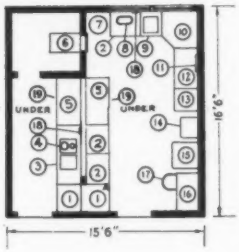
the most modern hospital furniture in the world

With Moduline you can provide furniture for your milk formula room, nurses' stations and laboratory rooms, that will meet your needs for years to come. Moduline, by Aloe, is styled for tomorrow. It comes in architecturally approved widths and depths so that custom-built facilities may be developed from standard Moduline units. Here are some characteristic details: concealed hinges, baked steel finishes with stainless steel table tops. Utilities can be top or splashback mounted. Write for special booklet T-300 and learn how Moduline can meet your furniture needs.

Special Schematic Layouts for Hospital installation available on request.



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newly designed

popularly priced

The development of the new Angelica hospital apparel line is the result of careful study and research by Angelica technicians in cooperation with leading hospitals and medical universities. Hospital uniform requirements determined in this study were the basis for the scientific construction of each garment to serve its specialized function. "TASK-TESTING" in the field is your assurance of complete satisfaction.

Angelica uniforms feature a wide range of long-lasting, high quality fabrics, durable construction, and have been awarded the American Institute of Laundering Seal of Approval.

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Prompt dependable service is assured by Angelica's national "on-the-spot" sales representation. Your Angelica representative is a highly skilled and experienced hospital uniform technician and is ready to assist you with any problem. In most principal cities he's as nearby as your telephone.

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HIGH QUALITY

DURABILITY

PROMPT DELIVERY

LOW COST

WIDE SELECTION

GREATER COMFORT

A Style 600—Raglan sleeve adult patient gown. Fully reinforced yoke with Angelica's exclusive "green-line" combed yarn tape neckline and ties. All points of strain are reinforced with bartacks. Ample sleeve opening to facilitate treatment. Garments amply sized for complete coverage (40" finished length), and comfort to the wearer. Choice of seven Angelica "laundry-tested" quality materials. Sizes — small, medium, large and extra large.

B

B Style 606 — Operating gown with tunnel belt construction. Roomy raglan sleeves and full 54 inches finished length. Extra overlapping back panels for greater sterility. Tunnel type belt checks contamination. Absorbent double stockinette cuffs retain elasticity. All strain points are completely reinforced with bartacks. Wide variety of Angelica "laundry-tested" materials including vat-dyed colors.

Yes, the new Angelica Hospital Apparel gives complete satisfaction for personnel in all departments of your hospital. This complete line of newly designed hospital apparel is offered to you at popular prices . . . giving you the double benefit of higher quality and greater economy.

A wide variety of quality materials are skillfully constructed into uniforms of character to provide the advantages of greater comfort, better fit and longer wear.

Be sure to see your "on-the-spot" Angelica Sales Representative with his complete line of newly designed, popularly priced hospital apparel.

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Individual sinks prevent congestion and splashing.

Made of Duraclay — immune to thermal shock.

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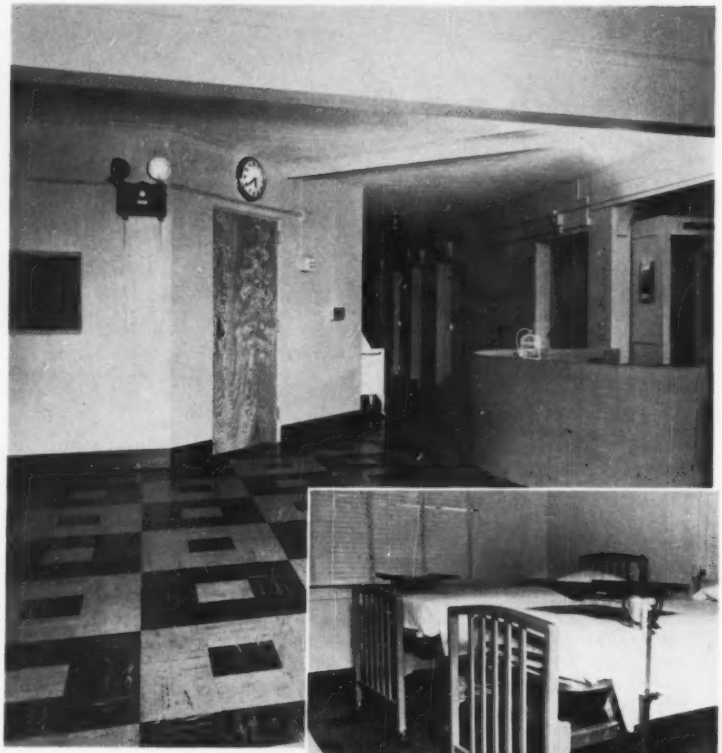
6 *big reasons why leading hospitals are installing* KENTILE FLOORS



LOW COST . . .

Inexpensive to buy . . . to install. For example, a minimum area of 1000 square feet may cost as low as 25c per square foot. Your floor may cost even less . . . or slightly more . . . depending on the design you select, the size, type and condition of your floor . . . and the freight rates to your city.

EASY TO CLEAN . . .

Mild soap and water keeps Kentile clean . . . occasional no-rub waxings keep it gleaming.

BEAUTY . . .

Colorful Kentile floors have a cheering effect on patients and staff.

SAFETY . . .

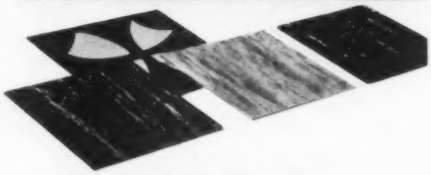
Provides a confident footing for all. Virtually fire-resistant.

DURABILITY . . .

Colors can't wear off. They go clear through the back of each tile.

QUIET . . .

Kentile is a resilient material that cuts down the noise and clatter of footsteps in corridors and rooms.



• BECAUSE it's laid tile by tile, Kentile is ideal for remodeling. It can be laid on any smooth, clean underfloor—even on concrete in contact with the earth, or on sound double wood floors.

Kentile is available in 9" x 9" squares, and in special sizes. Colorful ThemeTile and Kenserts—decorative squares with die-cut designs, pre-assembled, add character and color at low cost. Your Kentile dealer will be glad to show you these—plus Kenbase, the new easy-to-clean wall base, and *special* Kentile for Industry, the oil-proof, grease-proof, asphalt tile available for hospital kitchens. Look for the name and address of your Kentile representative in your classified phone directory.

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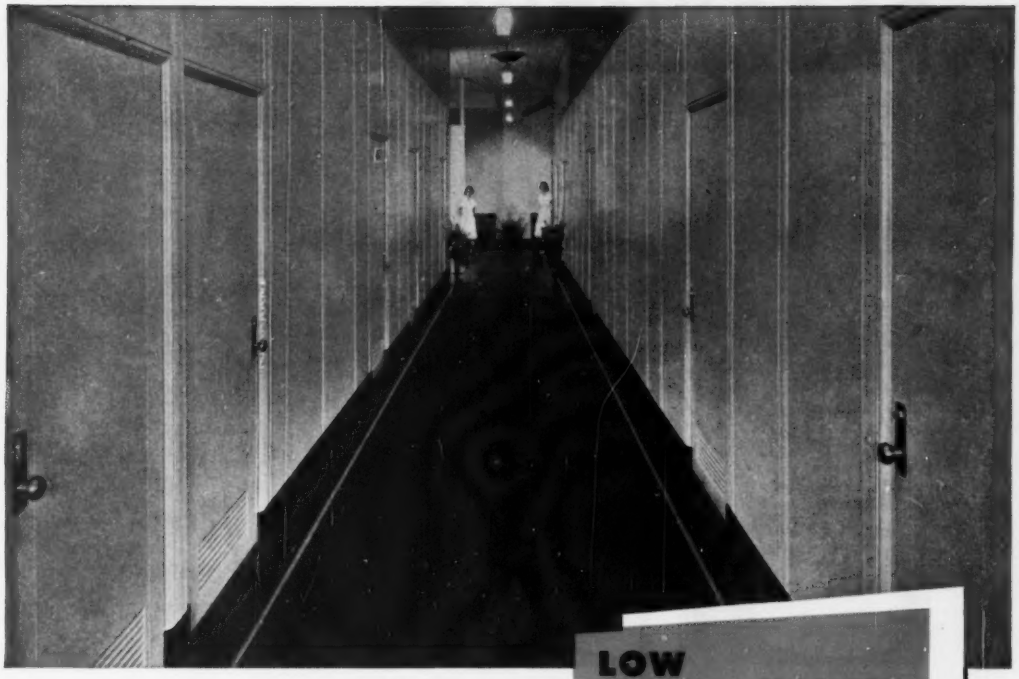
The Permanently Beautiful Asphalt Tile



This Hospital is Endowed with LOW MAINTENANCE COSTS

PATCHING and repainting ordinary hospital walls is a never-ending expense. But hospitals having Hauserman *Movable* Steel Interiors virtually eliminate this constant maintenance cost.

That's because Hauserman *Movable* Steel Interiors have a baked-on finish that won't chip, crack, warp or scale. This eliminates frequent patching and repainting. It means that a janitor can easily perform all the normal maintenance required . . . occasional soap and water washing.

Hauserman *Movable* Steel Interiors also assure efficient operation for the life of the building. Hauserman Steel Partitions can be easily moved whenever alterations or additions will make new floor layouts desirable.

A Hauserman representative will be glad to discuss these and all the other advantages of Hauserman *Movable* Steel Interiors with you, your architect and your contractor. Just call the Hauserman office or representative nearby or contact *The E. F. Hauserman Company, 6957 Grant Avenue, Cleveland 5, Ohio.* Or, if you prefer, we'll send you our fully illustrated 60 page catalog.

Organized for Service Nationally Since 1913

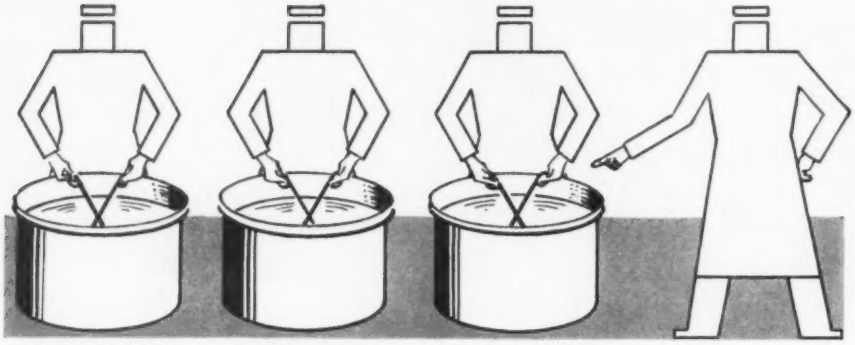
HAUSERMAN *Movable Steel Interiors*

Partitions • Wainscot
Railings • Acoustical Ceilings
Complete Accessories

PASSIVATING...

...the secret of keeping STAINLESS STEEL

STAINLESS



NOT ONCE NOT TWICE THREE TIMES

PASSIVATING, you will *not* find in the ordinary dictionary, but you will find it in the ARMY and NAVY contracts for stainless steel surgical instruments.

PASSIVATING, however, is truly the secret of keeping STAINLESS STEEL, *STAIN*LESS

The buyer-user of surgical instruments cannot see, nor sense, whether an instrument has been made of passivated steel, only time and use will bring out that knowledge, hence many manufacturers short cut — they either do NOT passivate at all, or passivate but once. Weck passivates all stainless steel instruments not once only, not just twice, but THREE TIMES.

Three times because experience and scientific testing has shown that this procedure gives more reliable results.

Naturally, therefore, an instrument made from Weck three-times-passivated steel will stay STAINLESS.

But passivating by itself is not the whole story, the manufacturer must start with the proper steel, then correctly heat-treat it, with pyrometrically controlled equipment.

There are several types of stainless steel in use. Type 410, the stainless steel specified by the Government, and generally adopted by manufacturers as the type best fitted for most forceps not possessing cutting edges, covers a range of chrome from 11% to 14%. The lower range produces an instrument which just barely possesses stainless steel qualities, whereas the higher range with the greater chrome content can, if properly handled, produce an instrument with excellent STAINLESS qualities. It is Weck's constant practice to insist that the 410 stainless steel they use be kept at the high chrome end of the specification. As a result of this Weck has been able to produce stainless steel instruments possessing high corrosion resistance and which STAY THAT WAY.

REMEMBER WECK INSTRUMENTS ARE MADE CORRECT — SOLD DIRECT — to HOSPITALS!

EDWARD WECK & CO., INC.

Manufacturers of Surgical Instruments

SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

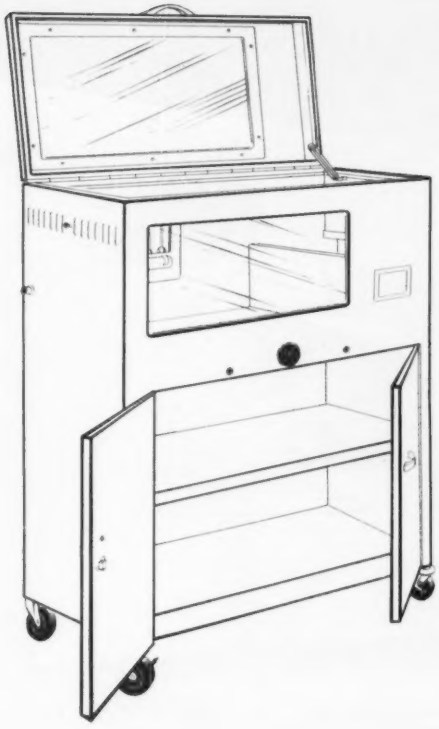
135 Johnson Street · Brooklyn 1, N.Y.

WECK

STAINLESS STEEL & CRODON The Chrome Plate

FOUNDED 1890

1940 in 1950?



A 1940 auto in 1940 was the best available, but a 1940 model is ten years behind the times in 1950. Likewise, incubators developed just a few years ago are far behind present day advancement in technology. The LIVSEY Infant Incubator is the only incubator available employing the principle of RADIANT HEATING. With Radiant Heating the air is not heated. Instead, heat waves are radiated through the air warming everything they touch. There can be no blasts of hot air for the infant to breathe. This gentle even heat provides the best possible environment for an infant. Value for value LIVSEY is best.

- Uniform Radiant Heating throughout
- Negligible heat loss when lid is opened to tend infant
- Easy to clean—heating mechanism located entirely outside the infant compartment
- Long lasting heating elements designed especially for our incubator
- One control
- Simple humidity regulation
- Most efficient oxygen connection available
- Blanket and clothes warming compartment
- Streamlined hospital type cabinet
- Fireproof construction
- Immediate delivery

Low original cost

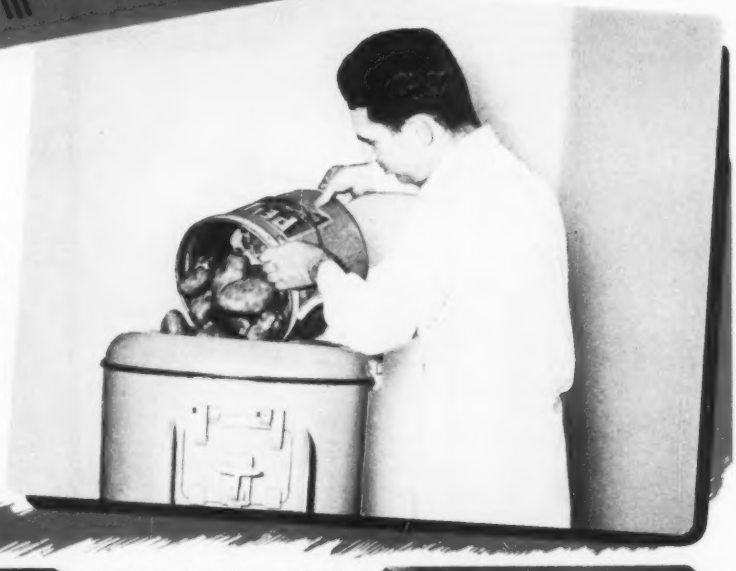
Low operating cost

The LIVSEY Incubator is guaranteed for one year.

Write to the LIVSEY Equipment Company, Dept. 11, 18938 Winslow Road, Cleveland 22, Ohio, for a free, descriptive brochure.

LIVSEY
INFANT INCUBATOR

does TALK work for you?



Talk up this idea and save money! "We save as much as $1.33 per 100 pounds of potatoes by following one simple rule," says Seymour Ginsberg, Vice President, Harmon's, New York City restaurant. "We teach our employees *always* to turn off our peeler at the end of the recommended 3 minutes. Running it longer can increase losses from the expected 22% to as much as 50%."

Talk about cutting costs! "Our cooks save hundreds of dollars a year by *always using* quantity recipes. They never rely on their memories," says Winifred Eliason, Greenfield-Mills Restaurants, Detroit, Cleveland, Columbus, Cincinnati. "Previously we found that food costs on one soup recipe alone had increased from 43% to 60% due to faulty memorizing."

"We've had lots of complimentary talk about the consistency of our fruit pies," says Kathleen Luddy, Ass't Chief Dietitian, New Rochelle, N. Y. Hospital. "We use Minute Tapioca to hold ingredients together and to keep fillings moist. Tapioca keeps fillings from becoming too rubbery or too runny—gives us perfect results."

PEOPLE WHO TALK ABOUT GOOD FOOD . . .

Talk ABOUT SAVING HIGH-PAID TIME!

Now you can prepare a month's supply of your basic baking blend at one time with Calumet's

'Ever-Ready' Blend

No more baking "emergencies." No longer will chefs or bakers have to neglect important duties to make up daily baking blends. Calumet's amazing "Ever-Ready" Blend lets you make up a *month's supply* of your basic blend *in advance*—saves you hours and hours of valuable time. Here's how you make it:

CALUMET'S "EVER-READY" BLEND
(13¾ pounds mixture)

10 pounds (10 quarts, sifted) flour
5 ounces (1 cup minus 2 tablespoons) Calumet Baking Powder
3 ounces (6 tablespoons) Diamond Crystal Salt
3¼ pounds (6½ cups) shortening

Mixer Method. Weigh flour, baking powder, and salt into mixer bowl. Mix on low speed (using flat beater) 5 minutes. Transfer to large dishpan or bowl. Cut in shortening until mixture resembles coarse meal.

Sifter Method. Measure sifted flour, 2 quarts at a time, into sifter. Add 1/5 of the baking powder and 1/5 of the salt for each 2-quart amount. Sift into large dishpan or bowl. Repeat until full amount of dry ingredients has been sifted. Then lift gently and stir to mix the different siftings. Cut in shortening as above.

Storage. Place in cans or jars with loose-fitting covers and store in cool, dry place. Keeps well for 3 or 4 weeks.

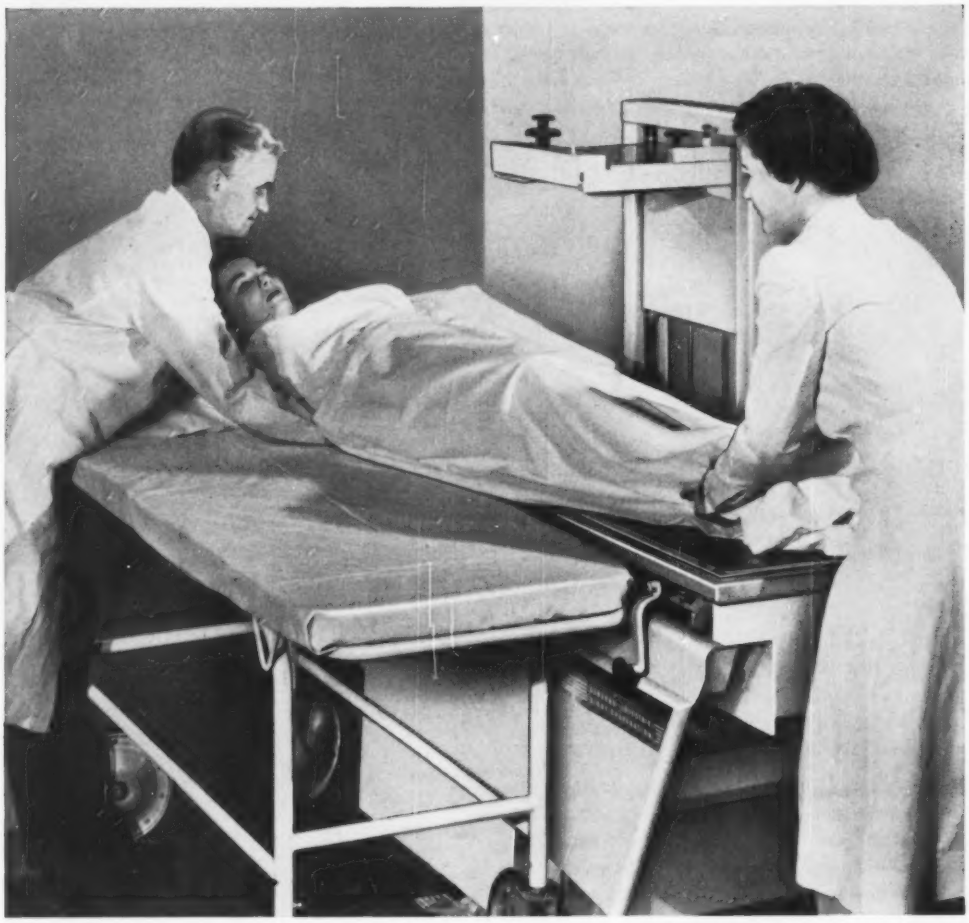
Used for every course. This basic blend may be used to make biscuits, muffins, waffles, pancakes, shortcakes and entrees. Write for free standardized quantity recipes for these and many other dishes to: Institution Food Service, General Foods Corporation, 250 Park Avenue, New York 17, N. Y.

Sure way to serve "talked about" food! Nicest thing most folks can say about food is: "It's as good as we have at home." So if you want folks to tell friends about your fine food—just use the same ingredients they use. That means outstanding products like Baker's Chocolate and Cocoa, Snider's Condiments, Minute Tapioca, Log Cabin and Wigwam Syrups and all the other General Foods Institution Products. They've been nation-wide favorites for years and years.

LAST CHANCE to win one of 30 BIG PRIZES in G. F. 1950 Contest. Enter before Feb. 28. Prizes for All! SEE JANUARY ISSUE THIS MAGAZINE FOR DETAILS

TALK ABOUT GENERAL FOODS!

It's NEW!



More than just a new x-ray unit, the Maxicon is a fundamentally new idea for a comprehensive line of x-ray apparatus. Specifically designed to grow with your practice. Yes, the Maxicon permits you to choose only the x-ray facilities you actually want or require — from the simplest to the most complete unit. Comprised of a number of components that can be assembled in various combinations, it covers the range of diagnostic x-ray apparatus from the horizontal x-ray table to the 200-milliampere, two-tube, motor-driven combination unit.

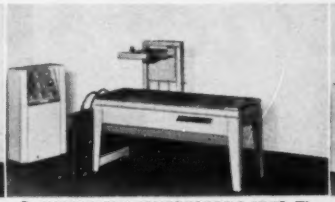
The Maxicon series has a wealth of utility wherever diagnostic x-ray is employed. The practicing physician may select the basic unit, then let x-ray grow with his practice — by simply adding successive components from time to time. The medical specialist may arrange to have only the x-ray facilities his specialty requires. The clinic or hospital will appreciate the application of a simple unit as auxiliary equipment in a busy department, or a complete radiographic and fluoroscopic combination to adequately meet the demands of any type of examination.

Discover for yourself the remarkable flexibility of the Maxicon. Ask your GE representative for unique booklet demonstration, or write General Electric X-Ray Corporation, Dept. H-2, Milwaukee 14, Wisconsin.

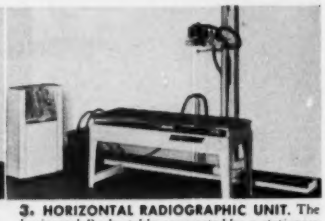
THE GE MAXICON...
designed to grow with your practice!

GE's Maxicon meets the medical profession's long-felt need for x-ray equipment developed to grow with an expanding practice...providing just the x-ray facility required—unit by unit as needed!

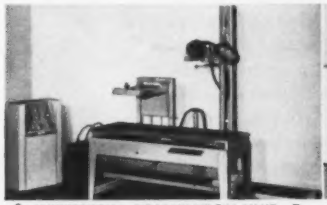
1. HORIZONTAL BUCKY TABLE. The horizontal table equipped for radiography includes a Potter-Bucky diaphragm mounted directly under the table top. For intermittent use at low milliamperages, with a mobile or portable-mobile unit, it makes an ideal unit for straight radiographic work.



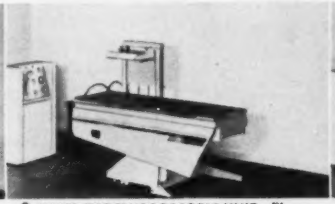
2. HORIZONTAL FLUOROSCOPIC UNIT. The basic horizontal table can be transformed into a straight fluoroscopic table by the mere addition of the fluoroscopic carriage and screen unit plus a tube mounted under the table. The 100-ma generator and Maxicon control complete the unit.



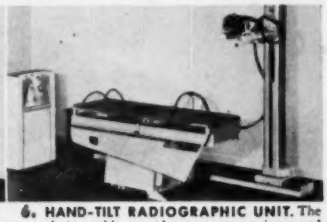
3. HORIZONTAL RADIOGRAPHIC UNIT. The horizontal Bucky table augmented by a stationary anode tube mounted on a tube stand and floor rail provides every facility for horizontal radiography. The 100-ma generator and Maxicon control provide for technics up to 100-ma at 90 kvp.



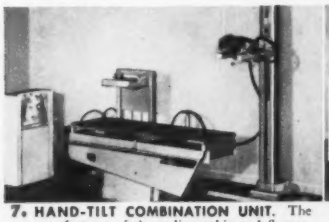
4. HORIZONTAL COMBINATION UNIT. For those who prefer a horizontal table to serve for both radiography and fluoroscopy this Maxicon combination unit is functionally unlimited. One tube serves as the x-ray source both over and under the table.



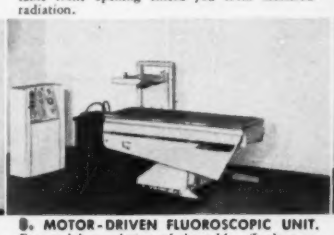
5. HAND-TILT FLUOROSCOPIC UNIT. Fluoroscopy from Trendelenburg to vertical is easily accomplished with this unit in the Maxicon series. Equipped with the spot-film device, an even greater range of service can be yours. Panels in the table-front opening shield you from scattered-radiation.



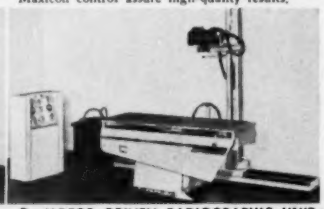
6. HAND-TILT RADIOGRAPHIC UNIT. The angulating table provides every convenience and facility to make radiography in angular positions an exact procedure. Manual raising of the table is effortless, supplemented by the power of a counterpoising spring. The 100-ma generator and Maxicon control assure high-quality results.



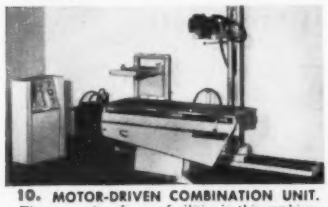
7. HAND-TILT COMBINATION UNIT. The separate features of the radiographic and fluoroscopic models are embodied in this combination unit. It can quickly and conveniently be adapted to every type of x-ray examination. Its outstanding flexibility permits the use of one tube for radiography and fluoroscopy.



8. MOTOR-DRIVEN FLUOROSCOPIC UNIT. Foot-pedal angulation of the table affords complete fluoroscopic convenience. The operator's hands remain free, for palpation of the patient and manipulation of screen and shutter controls. Scattered-radiation protection and an automatic field-limiting device are important features.



9. MOTOR-DRIVEN RADIOGRAPHIC UNIT. The variable-speed angulation of the Maxicon table is controlled by two conveniently located foot pedals. All degrees of tilt from Trendelenburg to vertical are self-retaining for radiography in any position. A complete range of power and capacity are provided by the rotating-anode tube.



10. MOTOR-DRIVEN COMBINATION UNIT. The composite of x-ray facilities in this combination unit equips you for complete radiographic and fluoroscopic service. The separate rotating-anode tube units increase the capacity of a busy department. The 200-ma generator and Maxicon control contribute the means for obtaining high-quality results accurately and routinely.

GENERAL ELECTRIC
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SUTURES IN ANCIENT SURGERY

Jehan Yperman

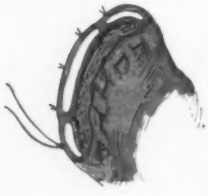
(1280-1351)

SUTUREGRAM

NUMBER SIXTEEN IN A SERIES

Suture of Bronchial Stump

After pneumonectomy collapsible portion of lumen of bronchus is approximated to that held rigid by cartilaginous rings.



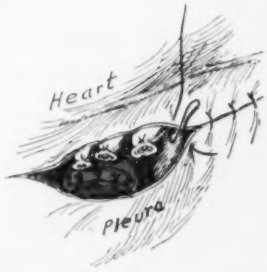
When mattress sutures are tied approximated edges are elliptical

SUTUREGRAM

NUMBER SIXTEEN (CONTINUED)

Interrupted sutures placed at very edge beyond mattress sutures help to make approximation airtight.

Visceral pleura is sutured over approximated bronchial stump and ligated blood vessels



JEHAN YPERMAN (1280-1351)—Yperman was one of the most famous pupils of the great Lanfrank, distinguishing himself both as a surgeon and an author on surgical subjects. Among his writings are lucid accounts of his method of arresting bleeding from an artery by the use of a "triangular needle" and a "stout waxed thread." He also gave good accounts of his methods of trepanning, treatment of arrow wounds and the suturing of the skin following an operation for hare-lip. Yperman was appointed surgeon to the Ospial del Belle at Ypres in 1308.

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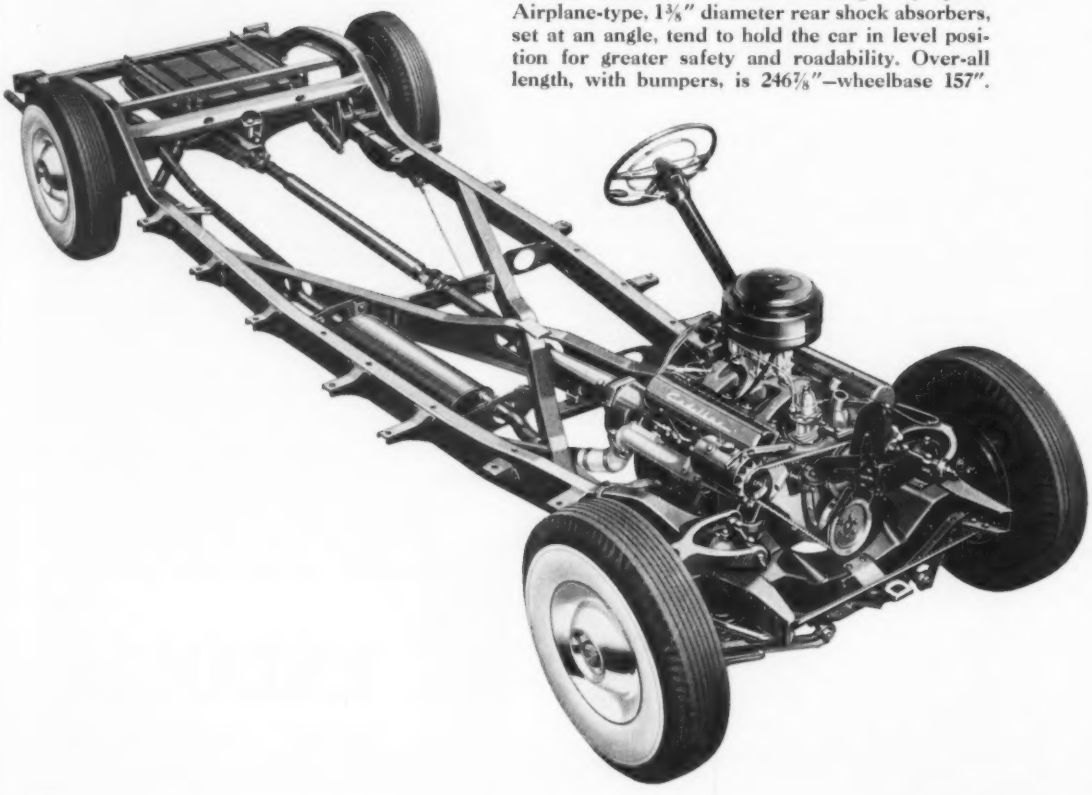
COMPLETELY

In the new 1950 Cadillac commercial chassis the engine has been moved forward. This permits a shorter wheelbase, without reducing body space. Airplane-type, 1⅜" diameter rear shock absorbers, set at an angle, tend to hold the car in level position for greater safety and roadability. Over-all length, with bumpers, is 246⅞"—wheelbase 157".



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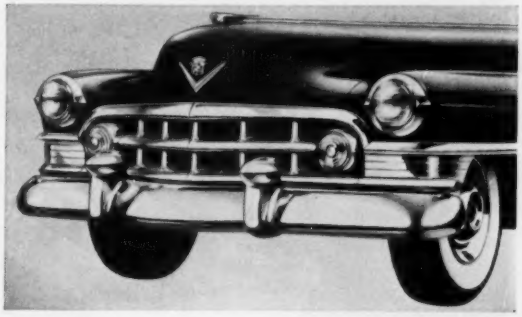
The Cadillac commercial chassis for 1950 has been redesigned and refined for even finer performance, better economy, greater convenience and more lasting durability in funeral car and ambulance service. It is built to the rigid requirements of commercial use without compromise in any way with passenger car design. The massive, new X-type, one-piece chassis frame, with boxed side members, is $7\frac{7}{32}$" deep —designed and built especially for this one purpose. The new Cadillac overhead valve, high-compression engine has been made even softer and quieter in operation, braking more positive, steering even steadier, and with a shorter turning radius for convenience in handling. It is the only chassis especially designed and built for funeral and ambulance service by the company whose name it bears. Specifications on this new chassis, as well as the newly-designed Cadillac-Fleetwood Series 75 seven-passenger Sedan and Limousine, will be found in the 1950 Cadillac Commercial Catalog – available on request.



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Johnson & Johnson

Small Hospital Questions

Where to Get Funds

Question: We are planning a hospital for our community and it seems likely that if we can raise about one-third of the necessary funds locally, we can obtain aid from public sources for the remainder of the cost. Can you refer us to a reliable lending agency familiar with the hospital field to which we might go for discussion of our financing problems?—E.S., Tenn.

ANSWER: As a general rule, hospital authorities and others who have studied hospital financial problems do not like to see a voluntary, nonprofit group borrow any considerable sum of money for a building project. Has your group consulted yet with an experienced fund-raising counsel to assess the possibilities for raising the money that is needed in a public subscription campaign?

Amortization and interest on loans to the hospital might make a heavy burden to carry through the years. This is particularly true if the hospital is going to do any considerable amount of outright charity work or take care of various indigent groups for state, county or city governments at rates which are frequently below cost. We always urge that the local voluntary hospital should have clear cut written agreements with city and county agencies specifying rates to be paid for care of relief, indigent and medically indigent cases. If possible, these agreements should specify that such cases will be paid for on the basis of the government reimbursable cost formula developed by the American Hospital Association several years ago, which is increasingly used by all kinds of agencies responsible for care of hospital patients. Failure to have this important matter ironed out thoroughly before the hospital is built may result in serious financial difficulties later on.

A Survey Is Safer

Question: A new 150 bed hospital is being planned for this area. The planning board is anxious to obtain the names and locations of hospitals of approximately this size which are considered outstanding, so that we might visit them.—J.B., N.Y.

ANSWER: We should like to warn against placing too much reliance on the practice of shaping hospital plans on features observed during visits to other hospitals. While it is, of course, helpful in many ways, especially for board members who are not familiar with hospital procedures, to make such visits, there may also be a dangerous tendency for one community to assume that its needs are the same as another's and thus to plan a hospital that may be unsuitable. The way to get a good hospital for your community is to have a careful survey made of your own area needs, then get a qualified hospital architect, and a competent consultant if necessary, to plan the structure and facilities required to meet the particular needs disclosed in the survey.

Central Oxygen Approved

Question: We noticed in December issue of The MODERN HOSPITAL that an oxygen piping system for the Columbia-Presbyterian Medical Center in New York City had been disapproved by the New York City fire authorities. We are planning piped in oxygen for our new hospital and want very much to have this included in the completed building. We are, of course, wondering what difficulties we may experience with our city fire authorities and how we can obtain proper clearance from them.—M.F., Ind.

ANSWER: The New York City fire authorities reversed their decision concerning the oxygen piping system at Columbia-Presbyterian Hospital and this project is now going forward with the full approval of the New York City fire marshal and the system is now in actual service. Most fire and insurance authorities are favorable toward the idea of central oxygen distribution, inasmuch as it actually eliminates some hazard by replacing many individual, high-pressure cylinders scattered throughout the building with one central source for oxygen, which is distributed at low pressures to the point of use. However, to be on the safe side, we suggest that you get in touch with the proper authorities in your city during the planning stage and carry out all specifications and installation details with the full knowledge of your local fire chief or other official and in accordance with his recommendations. —E. W. JONES.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

No Place for Fathers

Question: What is the accepted ruling about husbands in the delivery room? If they are not allowed, can the state hospital association make a ruling, so that hospital personnel may cite some authority to back up its policy?—M.E., Ill.

ANSWER: Most authorities feel strongly that the father should not be permitted in the delivery room. The addition of another unnecessary person always means an additional risk of infection, no matter how great the precautions, such as insistence on mask, gown and cap. Moreover, fathers may easily become ill or upset, especially during complicated deliveries, and distract the attention of doctors and nurses from the professional task at hand. No useful purpose is served by the father's presence, in the opinion of most doctors, although some do acknowledge that psychological comfort to the woman in labor justifies the risk and inconvenience. Regulations of the maternal welfare committee of the Chicago Board of Health, which under the direction of Dr. Herman N. Bundesen has maintained an excellent infant and maternity mortality record for a number of years, hold the delivery room sacred: "The delivery room shall be used exclusively for the obstetric care of pregnant, parturient or puerperal women, and for the immediate care of their newborn infants."

While it is possible that the ruling might be backed up by a local or state hospital association policy or health department regulation, it would seem wiser to take the time needed to explain to the patient and her husband that the policy is established in their own interest. Of course, cooperation of the patient's own doctor is needed to make the ruling stand up as a hospital policy. The subject should be discussed at a staff meeting, so there is clear understanding on the part of all doctors using the hospital—both as to the ruling itself and as to responsibility for enforcing it.

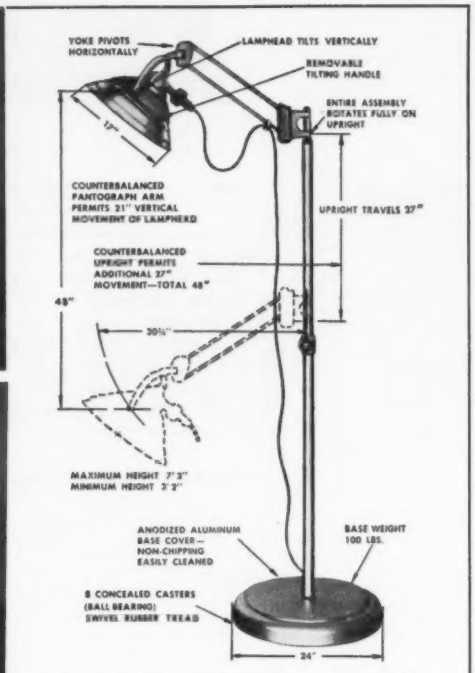

Illustration shows up and down range of 47", of which 21" is controlled by counterbalanced telescopic upright. Also note 21" floating adjustment of pantograph arm.

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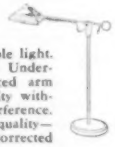
CASTLE 51 SAFELIGHT



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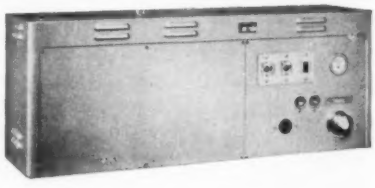

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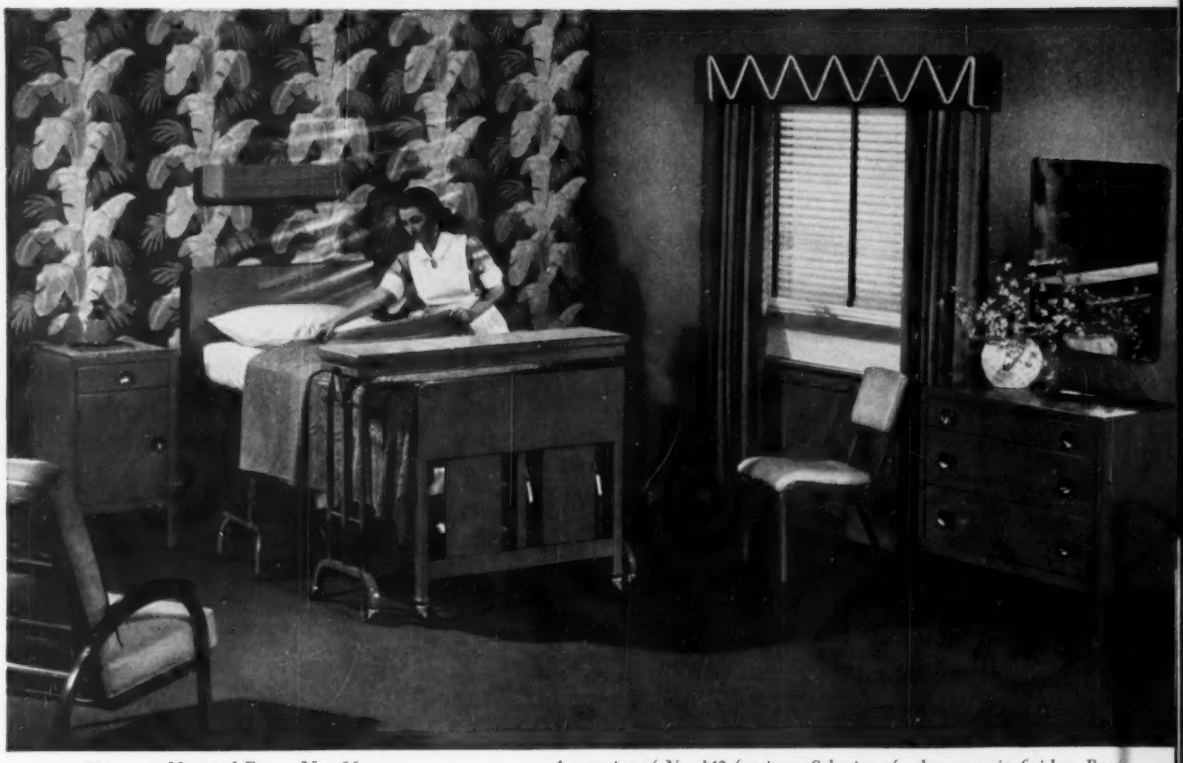
Wilmot Castle Co., 1271 University Avenue, Rochester 7, New York

LIGHTS AND STERILIZERS



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Looking Forward

Classification Clamor

IT IS probably not surprising that the interim classification of nursing schools, which said "I told you so" to the Brown report's "Horrors!" has met with more and louder opposition in a few weeks than the report itself did in a year and a half. Nursing and hospital executives who could afford to agree, or at least look the other way, when Dr. Brown said conditions were bad generally are now forced to squirm or fight back when the Committee for the Improvement of Nursing Service says, "Sister, this means you." Unquestionably, their anguish is the more acute for the haunting fear that omission from the classification could mean omission from the ranks of the deserving at the time the checks for federal aid are handed out under legislation now pending.

So far, however, opposition to the classification has failed to make its case stick. The accusation that classification is only a device for closing 25 per cent of the hospital schools apparently has to do with the intent in the minds of committee members, who can reply with equal logic that, on the contrary, the listing is intended to afford substandard schools an opportunity to analyze their failures as a necessary first step toward self-improvement—as many hospitals have done with the point-rating system developed by the American College of Surgeons.

Critics of the classification also point out that there aren't enough qualified instructors in the whole country to permit the present number of existing schools to meet minimum requirements. Does this argue for keeping the schools open anyway, with whatever kind of teaching can be managed? Or does it argue instead for concentrating available teaching talent in fewer but better schools, possibly with affiliation agreements permitting some clinical experience to be gained in small hospitals now operating schools that can't make the grade? The point is at least debatable.

Opponents of classification make the best sense when they claim that extinction of the smaller schools, if it should follow, would cut off the source of supply of nursing service for small hospitals. This might easily be true, and advocates of the fewer-but-better-schools program will have to develop some powerful recruitment logic to offset the appeal of the local hospital to the girl who is interested in a nursing career. Whether or not this can be done remains to be seen. In any case, small schools with half empty classrooms are not a strong argument for defense of the status quo.

When they leave professional reasons behind and join the political propaganda parade, classification critics simply stumble in the sawdust. "Confusion, discouragement and even despair exist among nurses, physicians and hospital administrators today," says a release from one such source, whose spelling and grammar have been corrected here in the interest of not making its case any worse than it is on the face of it. "It is well known that the above described conditions furnish fertile fields for the seeds of ideologies contrary to Americanism. The proposed program is contingent upon use of federal subsidy and therefore inevitable federal control. To knowingly accept such a proposed program is to aid and abet the enemies of free enterprise and freedom."

To read all these sinister meanings into a questionnaire survey of nursing schools aimed at paving the way for accreditation on the basis of unarguably pertinent professional standards is to leave reason so far behind as to make an answer difficult. The fact that confusion, discouragement and despair exist among nurses, physicians and hospital administrators today is unquestionably true; the same groups also have knowledge, ambition and hope, and both states of mind are equally well known among educators, lawyers, clergymen, insurance adjustors and chief clerks of minor departments in government bureaus. The inevitability of federal control under federal subsidy can be argued but not proved, and how acceptance of the interim classification would aid and abet enemies of free enterprise has not been established persuasively here.

A milder criticism of the program is that it has moved forward "swiftly and silently"—the implication being that the procedures and purposes of classification have been kept secret from those affected, and that if the same thing had been done with assurances of benign purpose, no one would now be suspicious or angry. This is hard to believe. Nobody who can read and write could have doubted that the committee's questionnaire was going to result in a ranking of some kind, and somebody has to be last in a ranking. Whether the tail-end schools are an "unlisted" 25 per cent, as in this classification, or whether they are labeled "standard" as opposed to "super" and "supercolossal," as in the case of canned peas, would seem to make little real difference. The poorer schools—always allowing for the few errors of judgment that are bound to occur—have been put on guard that they may be called on to justify their continued existence. Is this bad?

On Suffering

THE case of the Manchester, N.H., physician who injected air into the veins of an aged cancer patient to terminate life and relieve suffering has dramatized across the nation an issue that is often thought about and discussed by doctors, nurses and hospital people: Is euthanasia morally justifiable?

There can be no questioning the benignity of the physician's intent, nor can this be ignored by those who shall judge his act. Out of human sympathy, those who care for the sick may be understandably impelled to action in cases where continued life is hopeless and full of pain. At the same time, those who care for the sick should know better than most others that the sum of all man's knowledge has not yet stirred the veil that conceals the mysteries of life and death. So the moral judgment of our society is reflected in the law, which holds that deliberate termination of life, in whatever circumstance, is a wrong act.

The tortured physician and nurse, the anguished family and the suffering patient may find comfort in the epic struggle of Job:

"Man that is born of woman is of few days and full of trouble," cried Job, seeking death and relief from his woe. "He cometh forth like a flower, and is cut down; he fleeth also as a shadow, and continueth not. . . . I will speak the anguish of my spirit; I will complain in the bitterness of my soul. . . . My soul chooseth strangling, and death rather than my life. I loathe it; I would not live always; let me alone, for my days are vanity."

Out of the whirlwind, the Lord answered Job: "Who is this that darkeneth counsel by words without knowledge? Gird up now thy loins like a man for I will demand of thee, and answer thou me. Where wast thou when I laid the foundations of the earth? declare, if thou hast understanding. . . . Have the gates of death been opened to thee? or hast thou seen the doors of the shadow of death? Declare if thou knowest it all. . . . Who put wisdom in the inward parts? or who hath given understanding to the heart? Wilt thou also disannul my judgment? Hast thou an arm like God?"

Finally, Job gave his answer: "I know that thou canst do every thing, and that no thought can be withholden from thee. Who is he that hideth counsel without knowledge? therefore have I uttered that I understood not; things too wonderful for me, which I knew not. . . . Wherefore I abhor myself, and repent in dust and ashes."

And Job was rewarded with sons and daughters and sheep and camels and oxen, and he lived an hundred and forty years, and saw his sons, and his sons' sons, even four generations—and so died, being old and full of days.

No Bars, No Locks

THE specific cause of the hospital fire at Davenport last month remained in little doubt following admission by a schizophrenic patient that she had started a fire in her room. Whether or not the credibility of the confession would stand up in further investigation, however, it seemed likely that hospital personnel was not immediately to blame. Fire authorities stated that recommendations made following a recent inspection had been complied with; from a housekeeping standpoint, the operation was apparently orderly and safe.

However the fire originated, an automatic sprinkler system unquestionably would have stopped or delayed it sufficiently to have saved precious lives and property. Considering the age of the building and the nature of the interior structure, a sprinkler system was certainly needed; the operators of unsprinkled hospitals of this age and type can never be entirely free of reproach when disastrous fires occur. In this case, however, a sprinkler system was not mandatory under the city's building code, so city authorities may share responsibility for the fact that the building was thus unprotected. Whether or not supervision was considered adequate in view of the nature of the building's occupancy was not disclosed in the early hearings. Meanwhile, the lesson for other hospitals must be that automatic sprinklers and complete supervision are worth whatever they may cost.

Another tragic aspect of the Davenport fire is highlighted in the article by Dr. D. Ewen Cameron on page 84 of this magazine. Fire authorities at Davenport reported that many patients were prevented from escaping from the burning building by bars on the windows and locks on the doors, which also delayed the entrance of firemen seeking to combat the fire and evacuate patients. Yet bars and locks have no place in the modern psychiatric ward, according to Dr. Cameron, who is director of the Allan Memorial Institute of Psychiatry at Montreal, where he has operated a completely open psychiatric hospital for years.

"No fault more frequently mars and distorts the provision of psychiatric facilities in general hospitals than that of planning for the extreme case," Dr. Cameron states. "Because 2 to 3 per cent of the patients may be actively suicidal, or the occasional patient may be noisy or violent, [it is mistakenly believed that] all the patients must be kept under lock and key; all the windows must be barred or otherwise protected."

Describing his experience with psychotic patients at Allan Memorial Institute, Dr. Cameron says: "The doors are not locked, and yet the movement of patients from one ward to another and from the institute into the city is not haphazard or impulsive. There have been three suicides in five years, and no serious injuries owing to violence have taken place.

"If you are planning to open a psychiatric department in a general hospital," Dr. Cameron concludes, "do not let it be a 'locked' section. Do not compromise by opening part of your psychiatric section and locking the rest. No modern psychiatric division can survive half locked and half open. You cannot just lock up your problem and go away and leave it."

Locks and bars caused death at Davenport. Wherever they remain, it could happen again.

THEY MADE THEIR OWN HOSPITAL

KARL DETZER

Photographs from Minneapolis Star and Tribune and Duluth News Tribune.

The schoolhouse which Dr. Snyker and his helpers turned into a hospital.

A SLOVENE miner named John stood near the shaft of one of the world's deepest iron mines at Ely, Minn., one evening in 1947, watching the day shift come off duty. He studied the soiled, tired faces of his fellow-miners as they came blinking into the light, finally stepped up to a group. "Wanna work tonight, boys? Doc needs us."

"Sure," they agreed. "Sure, we work."

They were five big men, patched and grimy, with stooped shoulders and massive hands. Like John, they conversed in heavy Slovene accents. They crowded into John's jalopy and sat with lunch pails on their knees as they rattled three miles over country roads.

John halted in front of a sturdy, two-story schoolhouse in the hamlet of Winton, which is really only an extension of Ely. The school had been built in 1906 when there still was timber to cut and Winton was young, with dreams of greatness. Now the children went by bus to a consolidated school and the old building stood vacant.

Inside the former schoolhouse, hammers were pounding and a saw whined. Men hurried, with tools in their hands. John and his friends hesitated in the doorway.

"Hi, John," a cheerful voice called from the stairs. "Thought you'd come. Who you got there?"

It was Doc's voice. He was coming down the stair, his arms full of lath. Doc was a middle-sized man with broad shoulders, sandy hair and deep blue eyes. He wore overalls and a carpenter's cap.

"Boys wanna work mebbe two-three hour," John said.

Dr. Omar Snyker sized them up and nodded. "Tearing out that basement wall tonight," he said. "Getting ready for the new boiler. Need someone to haul out bricks."

The schoolhouse that 1947 evening was cluttered with pipes, coils of copper wire, sheets of stainless steel, sacks of cement. Blueprints tacked to the wall showed this stairway where Doc paused as an elevator shaft, the classroom over there cut into three small wards.

Today the elevator is running; there are patients in the wards. Instead of the sound of hammering there is the cry of new babies. Thanks to the civic spirit, skill and capable hands of John and 150 other men from the mines, to hard work done without pay by woodsmen and fishing guides, merchants and barkeepers, lawyers and truck drivers—and many of their wives—the towns of Ely and Winton have a bright and busy new hospital instead of an unused school.

Townsmen like to say that the genius of Dr. Omar Snyker got them their hospital. Snyker denies it. But if genius is a composite of perseverance, audacity and imagination, plus an ability to work 18 to 20 hours a day, then it was this country doctor's genius that turned the trick. At any rate, it was he who persuaded the men to give an average of 30 ten-hour days of their strength and skill in a little more than two years. It was he who cajoled housewives, stenographers and teachers into pulling nails, sanding, scrubbing and painting woodwork. He talked 650 other residents of the two towns and surrounding woodlands, not one of them rich, into turning over $39,500 in cash in exchange for certificates making them part owners of the institution. He wangled the schoolhouse from the village at a rental of $25 for 25 years, begged and borrowed equipment and building materials, bullied an architect friend into making the drawings, improvised endlessly until he had the hospital functioning.

The two communities of Winton and Ely, with a combined population of 6500, used to share a single 16 bed hospital in an old frame house which 60 years ago had been a rich lumberman's home. It still is operated as a private institution. But many townsmen long had talked about a community hospital in which they all would have a share. No one did anything about it till the "new doctor" came to town.

Omar Snyker was a plumber's son from St. Paul who had put himself through medical school in Chicago by working in a dairy, then been a doctor in the army and in north woods CCC camps. He came to Ely because he liked fishing and the near-by lakes furnish some of the best in the world. Slowly he began to build a practice, chiefly among the Slovene miners and

their families. Some of them talked to him about their dream of a hospital. Snyker made it his dream, too. One day he drove past the abandoned schoolhouse. "The idea hit me," he says, "that here at least were a roof and four walls."

There was no chance to do anything about it until after World War II. As a flight surgeon in Europe, Snyker was too busy to think much about the old school back home. He did, however, save $1000 from his army pay. This, when he returned to Ely, he put into what he called "the hospital fund." Some friends added a few more dollars. With that capital Snyker set to work.

One evening at its regular meeting the Winton town board was surprised by a visit from the doctor and a group of his supporters.

"We want to rent the school for 25 years and make it into a hospital," Snyker said. "We can pay a dollar a year."

The board agreed, and Snyker went out into the streets and began to sign up pledges. Dubious citizens asked what they'd have to show for their money.

"The hospital," Snyker said. "But we'll make out some certificates, too."

What these certificates are worth in cold cash is anybody's guess. The hospital pays 2½ per cent interest on them. The building still belongs to the town; the equipment is in Snyker's name.

On July 5, 1947, Snyker and the first volunteer workers launched their attack on the dusty building. While truckers hauled gravel, cement and lumber at no cost, members of the American Legion rummaged in cellars and backyards and came back with hundreds of feet of water pipe, mostly in short pieces. Carpenters donated their evenings, after hard days of work, to carefully taking up the old floors and laying new. Miners from the night shift gave daylight hours; day-shift miners worked evenings.

Husbands and wives came by the dozens, asking how they could help. Omar Snyker always found plenty for them to do. Some women were put to work beside their husbands, discovered unexpected skill with hammer and nails. Others gave bake sales, put on local talent shows or knitted mittens for the cause. Still others brought brooms and kept the building neat while the work went on.

Arni Corpi and his wife lugged home the old venetian blinds, took them apart, scraped, sanded and varnished each of the 3380 slats, strung them back together and hung them where they belonged. Edith Ellefson, the local artist, collected all the old steel engravings of Washington, Lincoln and Columbus which had hung dingily on the schoolhouse walls, scraped and refinished the oak frames, filled them with her own paintings of near-by lakes and hills, hung them in the waiting rooms.

The first patient was wheeled into the hospital less than two years after the first hammer started to pound. There now are four wards of four beds each, with room for two more beds to a ward. There are four other double rooms and a few single rooms which in time will become double. The capacity gradually will be expanded to 40.

Much of the equipment for the hospital came from surplus army and

Top of page: Scrubbing, sanding and polishing, the women of Ely and Winton made the hospital's kitchen gleam. Below, left: Mrs. Arne Pennake polishes the sterilizers. Below, right: Albert Dargontina puts his talent as a machinist to work for the new hospital.

Left: Dr. Snyker at work installing the x-ray machine. Right: The waiting room is equipped with attractive furniture and draperies. A local artist, Edith Ellefson, contributed the paintings that hang on the walls.

navy stocks. The rest was built with materials at hand. Old kitchen tables covered with stainless steel glisten in operating and delivery rooms and diet kitchen. The marble slabs in the laboratory once were the backboards bolted to the wall in the schoolhouse toilets. Desks, chairs and office equipment — picked up for what Snyker calls "a song and a dance" in second-hand stores and out of local attics — have been refurbished by volunteers, look like new.

Actual cash outlay for the new hospital, met through gifts and the sale of certificates, was slightly under $50,000. Its worth is probably five times that. A board of townspeople operates the institution, with Snyker as its president. The board members include a forest worker, a woman storekeeper, a lawyer, a mine safety engineer, a fishing camp owner and a miner. Local folk still contribute work, money and food. Until the laundry was finished, long after the hospital began to function, women volunteers carried the linen home, washed it, returned it to the shelves.

Not long ago the members of a women's club, after raising $400 to buy a walk-in refrigerator, found themselves still $700 short. Rather than wait the several weeks it would probably take to raise the rest of the money, they decided it would be better to borrow it.

A delegation appeared one morning at the desk of the local bank president. "Dr. Snyker needs that refrigerator right now," they said. "We have $400 and want to borrow $700. Our only security is our reputations. You know they're good."

The banker agreed quickly. He got out notes for them to sign. When he mentioned interest, the women were astounded.

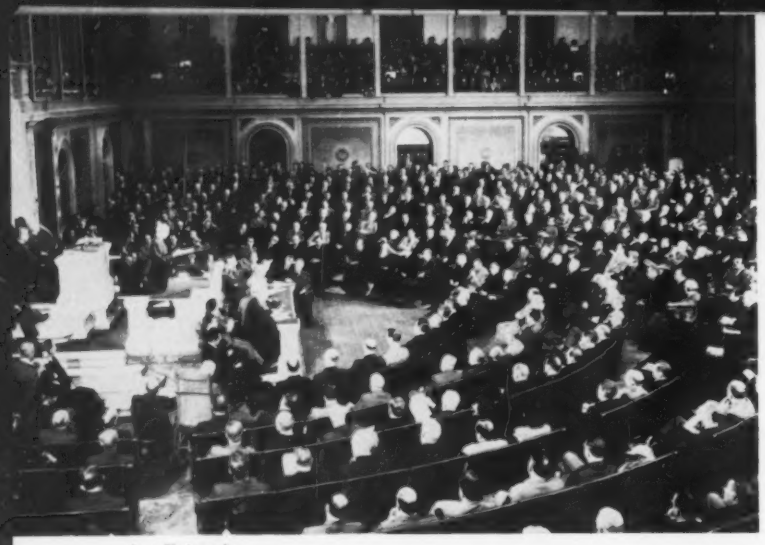
"It's for the hospital!" they said. "Either you or the bank will pay the interest!"

"Why, yes, of course," the banker said. "I just hadn't thought of that."

The hospital has its refrigerator now. It also has a new microscope, thanks to the ladies; and a well equipped x-ray room; and an incubator in the nursery.

Because their own sweat and fatigue went into the building of their hospital, the people of the two little towns are extremely proud of it. They have named it the Ely-Winton Memorial Hospital, in memory of their war dead. But it is a monument, as well, to the plain people who were willing to work long hours for what they wanted, not for themselves alone, but for their community.

Left: Setting up the renovated venetian blinds. The job of taking apart the old blinds and scraping, sanding and varnishing each of the 3380 slats, and restringing them was undertaken by Arni Corpi and his wife. Right: Louis Gorni, plasterer, contributed his services, too.



Acme Photograph

Addressing a joint session of the Congress in January 1949, President Truman called for enactment of a national health program including compulsory health insurance. This demand was renewed in the President's State of the Union message in January 1950.

The Voluntary System Can Survive the Truth

the job of public relations is to tell it

R. M. CUNNINGHAM Jr.

AS AN important part of my indoctrination in the public relations counseling business years ago, the difference between public relations and publicity was explained to me at great length. True public relations had to do with every phase of management policy and operations, it was explained; the public relations counselor so guided the business or institution he served that public interest and opinion were automatically engaged and improved. Employment, design, manufacture, sales, pricing, collections, credit—these and every other aspect of business needed thoughtful analysis and study by the public relations expert, whose recommendations would then alter basic procedures in such a way that public good will would flow in like oil from a Texas well.

Publicity, on the other hand, was just a method. News releases, radio programs, magazine articles, billboards, displays, pamphlets and so on—these were simply tools that were useful to have around at various points in the operation when it seemed desirable to spread information or create a certain impression in the public mind—an entity, by the way, of whose existence I am considerably less certain today than I was then.

I didn't quarrel with these definitions and distinctions between public relations and publicity then, and I couldn't quarrel with them now. I suppose they are perfectly legitimate. I didn't, however, get much chance at that time to observe these theories in operation for the reason that my employer was a conscientious man who believed every word of the doctrine he taught. A company or institution would engage him as public relations counselor and he would immediately make recommendations having to do with operating policies. The management would suggest that he should get busy putting their name in the papers and let them run the business. When he insisted that running the business right and good public relations were the same thing, he would get thrown out. This happened right along.

Since that time, I have talked to a great many public relations people. Without exception, they have been at pains to explain the difference between public relations and publicity. I have met hundreds of public relations people; in fact, I have even been one, but I can recall meeting only one man who said frankly that his job was publicity. This was a hearty fellow whose clients included retail stores, manufacturers, educational institutions and orchestral associations. When times were bad he wasn't above picking up a few dollars as press agent for city and county politicians. I asked him once why he wasn't a public relations expert instead of a publicity man, and I still think his answer is revealing. "It isn't consistent with continued gainful employment," he said.

The difference between the two was the subject of a full-length feature in a recent issue of *Fortune* magazine, which dusted off the familiar story of Ivy Lee and the Rockefellers and went on to trace the development of public relations to its present top-management, policy-making status in many businesses. More and more, *Fortune* predicted, the top executives in business and industry will be primarily public relations people.

Unquestionably this is true, and probably it reflects significant changes in our whole economy. The day may

Condensed from a talk presented to the National Blue Cross-Blue Shield Public Relations Conference, July 1949.

be past when presidents of railroads, public utilities and manufacturing companies were largely selected from the ranks of technical or operating executives, and the day may now be passing when they were selected for their wizardry at corporate finance or law. Increasingly today the problems of business have to do with labor and industrial relations and with finding and exploiting markets, so increasingly today it is the man whose talents lie in these areas of human relations who is chosen for top responsibilities. The phenomenon is not by any means confined to the business world, as the selection of General Eisenhower and Governor Stassen for university presidencies readily demonstrates. Their careers have followed radically different paths, but the genius of both these men is plainly in public relations. Or is it publicity? The fact is that all the more recondite concepts of public relations make it simply an essential part of wise management. In the popular understanding of the terms, however, public relations remains distinguishable from publicity chiefly by added overtones of intelligent planning.

Whatever you want to call it, there is a general feeling abroad today that we need a lot of it in the medical and hospital fields. Doctors and hospitals are grievously misunderstood and mistakenly mistrusted, it is held, with the result that a few evil men who want to change the system have gained unwarranted attention and support for their sinister schemes. Here is a job for public relations. The formula is simple: By every possible means, instruct the public in the triumphs of private practice and voluntary hospitals in the United States and the failures of socialized medicine everywhere else. In text and pictures, glorify the doctor and nurse and vilify the bureaucrat and his contemptible companion, the do-gooder. And, to be sure, sell voluntary health insurance plans, being careful, of course, not to integrate their activities to a point which will give control to a board of directors with lay members.

Stated perhaps in absurdly oversimplified terms, that is nevertheless in essence the program that has been developed and promulgated by serious-minded people as the answer to, and the best method of combating, the administration's proposals for a nationalized health service. To judge whether it is a good or bad public relations program, we must examine specifically the goal that it seeks to accomplish and then try to assess the likelihood that it will achieve its goal better than any other method would.

From time to time it has been delineated in much loftier language, but the main objective of the program is unquestionably to turn back the threat of socialized medicine. Whether or not this is a good goal depends on what we mean by the term socialized medicine. Probably there is nothing to be gained by laboring a definition here, but one point should be established: For all of us, the meaning of the term is changing all the time. Ten or twelve years ago, for example, Blue Cross was considered by many doctors and many others outside the profession as a form of socialized medicine. Today, of course, Blue Cross is regarded by these same groups as the first and strongest line of defense against socialized medicine. Most hospital people today believe the Hill Bill, providing aid for indigents through Blue Cross and other voluntary plans, is a good thing, but, of course, there are many people who think *this* is socialized medicine and an evil thing. Most of us in turn apply the words to a bill which among other provisions would add hospitalization and medical expense indemnities to Social Security, but if the day should come when this step is taken we won't call it socialized medicine any more. We will then use the words instead to mean some further, still more centralized and socialized program, and we will still be against it.

Specifically, one of the public relations tasks that medical and hospital and allied groups have set out to accomplish is to defeat this legislative program. While there are some good, or at least questionable, things about the so-called compulsory health insurance bill (such as grants to states for medical education and research and for support of public health services in rural areas) most of us agree that its main provision is a bad thing because it would not accomplish its worthy aim of eliminating any economic barrier that may exist between American people and good medical care. On the contrary, we believe that it would be disastrously expensive and difficult if not impossible to administer, and that eventually it would have the opposite result of deteriorating the quality of medical care generally and thus making good care less rather than more widely available. Most important of all, we believe there are better ways of achieving the worthy aim.

Assuming that we are right in these judgments, it should be possible to demonstrate our rightness and so create a powerful, conclusive argument against the thing we are seeking to defeat. This has not been done. A great deal of money and talent has been poured into an effort to demonstrate that there is no economic barrier between American people and good medical care and anybody who says there is is a socialist, that President Truman's proposals are a Threat to Freedom and an Open Door to the Socialist State and Despotism, that the idea originated in Foreign

THROUGH HISTORY WITH J. WESLEY SMITH

"Bread and circuses! Bread and circuses! What I want is social security!"

"... an awe-inspiring number of doctors, interns, residents and students"

Countries and is master-minded here by the Moscow-dominated Communist Party, that Political Medicine would "disregard the beliefs and principles of religious and fraternal groups," and that it is "one of the final, irrevocable steps toward complete state socialism" and "one of the lures used to lull people into nonresistance while complete enslavement is accomplished."

In trying to judge what these assertions may be expected to accomplish, it may be worth while first to determine what they mean and whether or not they are true. It seems fair to say that all these allegations are reducible to three basic concepts: (1) that compulsory health insurance is foreign as opposed to American, (2) that it is socialist as opposed to capitalist, and (3) that it imposes a restriction on individual freedom of action. Certainly there is some truth in each of these concepts. It is certainly true, for example, that the health insurance idea originated and was tried out, with fairly dismal results, in a number of foreign countries before it was proposed for the United States. Whether it is also true, as this "foreign origin" concept definitely implies, that federal health insurance is actually in conflict with the political principles that we think of as exclusively and desirably American is much harder to say. There is nothing in the first 10 amendments to the Constitution of the United States, our precious Bill of Rights, that specifically opposes or rules out a national health program. The ninth amendment asserts that the enumeration of certain rights in the Constitution shall not be construed to deny or disparage other rights retained by the people, and the tenth amendment says that powers not delegated to the federal government by the Constitution are implicitly reserved to the individual states or to the people. Our courts have not seen fit to rule against social security, of which health insurance is a phase or kind, as unconstitutional and hence unAmerican on the basis of these two amendments, but the courts could be wrong.

The belief that federal health insurance is socialist as opposed to capitalist is much easier to assess. It certainly is. It is socialist in the popular sense that it passes to society, as represented by the federal government in this case, certain functions that heretofore have been performed by individual producers and consumers—in this case of medical and hospital service. In this sense the Hill Bill is socialist, too. So is the Hill-Burton Act, and the Social Security Act itself and a number of other laws that were passed during the New Deal and many that preceded the New Deal—as far back, in fact, as the time of Alexander Hamilton. Federal health insurance may also be socialist in the Fabian sense that it would diminish competition and act as a leveler of social opportunity — at least opportunity of a certain kind. In this sense it is probably more socialistic than any of the measures which have preceded it. I doubt that it is really socialistic in the so-called scientific or Marxist sense under which the state is sole owner of all the means of production, however, and I doubt that there is much truth in the belief that the advent of scientific or Marxist socialism would be aided or speeded by federal health insurance. It can be argued with some logic that the exact opposite of this would be the result, but it is an argument without proof or profit on either side.

Finally, the concept that health insurance imposes a restriction on individual freedom of action is undeniably true; the individual would be paying for and therefore virtually compelled to get service at the designated hospitals and from the designated doctors. This is a bad restriction for those whose freedom of choice today is bringing them the needed services at prices they can afford to pay. Obviously, it would be a meaningless restriction for those who can't get or can't pay for the services they want. The number of people in this situation is in dispute, but it is undeniably a fact that there are some restrictions on individual freedom of choice under the present system, too, and the people who are chafing under existing restrictions are not likely to be impressed by conversation about a new set of restrictions. This is a point that gets overlooked in public relations.

Plainly, however, there is some truth in all the basic assertions now being made in the public relations effort against federal health insurance, or what we now know as socialized medicine. The question still remains: Is this the best way to turn back the threat? Those who are engaged in the program make the reasonable point that the bill never got out of committee in the last Congress and has lost the current support of some of its early enthusiasts—a circumstance that is unquestionably due in part to the uproar they helped to raise. In trying to judge what is likely to happen next year, or the year after that, or still later on, however, it is impossible to ignore the central fact that a commanding number of American people want some other way of financing their medical care than the individual fee-for-service basis that has prevailed in the past. The existence of Blue Cross, 35,000,000 strong today, is persuasive evidence of that fact. Blue

Shield plans are coming along fast in the footsteps of Blue Cross, also plainly in response to public demand, which has been strong enough in many areas to overcome continued resistance on the part of many of the doctors who are expected to provide the service.

This demand is bound to be fulfilled, because our social organism ultimately has to be responsive to the will of the people, just as our political organism ultimately has to be responsive to the will of the voters. To the extent that voluntary agencies fill the demand, political pressure for a federal medical prepayment system will be eased, and to the extent that voluntary agencies fail to fill the demand, political pressure will increase. In the long run these processes will be comparatively unaffected by the frequency or fervor with which various legislative proposals are called foreignisms, or socialism or totalitarianism—even if those are fairly accurate labels. To the extent that the public relations effort of hospitals and medicine is devoted to extending the good work that they do to larger and larger groups in the population, it should be successful and win the fight against government intrusion. To the extent that the public relations effort is devoted to helling around about socialized medicine and statism and freedom of religion and what happened in Germany in the 1870's, it is at best a diversionary action and at worst a waste of time; in either case it can have little to do with the ultimate result.

President Conant of Harvard University has recently made the point that the distinguishing characteristic of American society, the one that is really behind all the different things we mean when we use that vague phrase, the American Way of Life, is its fluidity. There are lamentable exceptions of course, but we have achieved the nearest approach the world has yet known to a society in which there is free movement from class to class. We do have social and economic classes, of course, but we are less stratified socially and economically than any other major country in the world today. It is obviously more difficult for some than for others, but it is nevertheless a fact that by his own effort and intelligence a man may move with his family from one class to another. This fluidity is a greater triumph, and a greater asset, than many of us realize. So long as it prevails, we shall be comparatively free from the class antagonisms that have emerged in other countries to overthrow governments, economic systems and even whole civilizations. What contributes to freedom of movement between classes contributes to the strength and safety of America, therefore, and what restricts movement between classes threatens America. By this yardstick, for example, the inheritance tax is a good thing because it tends to diminish social stratification by birthright, or inherited wealth, and the income tax is a bad thing because it diminishes the rewards a man can earn by his own unaided efforts. By this yardstick the socialization of education is a good thing because it tends to equalize the opportunity and equipment with which men start their economic life. By this yardstick the socialization of health services would be a good thing if it accomplished this same result of equalizing opportunity.

I am suggesting here that health service, like educational opportunity, is not one of the rewards that a man works to achieve but rather part of the equipment with which he should start on an equal footing with his fellows. To think otherwise is to give children born into comfortable circumstances too great an advantage to begin with, and hence to encourage the stratification we want to avoid. We who oppose a federalized health service, however, don't think that it would accomplish that aim of equalizing opportunity. We think we can come closer to this goal by using and strengthening existing methods and resources. Perhaps we should get busier using and strengthening them for this commendable purpose, then, and not expend so much time and energy applying labels. The thing that should concern us most is not so much the difference between infant and maternal mortality rates in the United States and Germany, or Britain, or New Zealand, as the difference between infant and maternal mortality rates in New York and Alabama. The gap there is a threat to our voluntary health service system for the very real and painful reason that it reveals a failure of the system. Unless we can diminish and finally eliminate its failures the system will not last, no matter how great or gaudy the effort to show that we may be exchanging it for one whose failures will be larger instead of smaller.

What should medical and hospital groups be doing, in addition to what they're doing now, to use and strengthen existing methods and resources? The answers are all fairly obvious. They should be doing everything that tends to equalize health service opportunity. Spreading Blue Cross and Blue Shield membership, certainly, for one thing. The plans for a national Blue Cross-Blue Shield health service would be a great step toward an integrated voluntary system that would answer the national demand. The

Ward care is not the same as private room care.

Hill-Burton Act has been a great step. The Hill Bill would be another. A program for the expansion of medical and nursing education, so that we can be sure to staff the facilities we are planning and building today, would seem to be a necessary step. It may be impossible to accomplish this without government aid. Is that socialism? Does it matter?

SOMETHING ELSE MUST BE DONE

Most of these things, of course, are already being done; to the extent that voluntary agencies can speed and intensify the effort, their programs are making a valuable contribution. But there is something else that needs to be thought about, too, something that may be getting too little attention today. Possibly this is also a task for medical and hospital public relations. A part of the national medical care problem today may develop from the circumstance that we have permitted, or perhaps encouraged, a qualitative interpretation of the difference between specialty and general practice and the difference between private and ward care. In a materialistic society such as ours it is probably inevitable that we should think that what is expensive is good and what is cheap is bad. Possibly it was unavoidable that this same kind of evaluation should have emerged in the medical field. The services of the specialist are better, because more expensive, than the services of the general practitioner, it is widely believed, and private room care is better, because more expensive, than ward care. We keep telling one another that this really isn't so, and we keep asserting in our publicity that it isn't so, but we haven't made much of a dent in popular opinion on this point. Many of us, in the larger cities at least, commonly take our medical problems directly to the specialist and haven't seen a general practitioner for years. What is even more revealing, many of us have been guilty at one time or another of bragging about how much it cost to have a baby, or an operation, or an illness of some kind. Expensive medical care is more fashionable than inexpensive care; it is socially more acceptable in the same way that a Cadillac is more fashionable and acceptable than a Ford, and an address on Park Avenue is more acceptable than an address on Tenth Avenue. However superbly our present medical system may provide for the patient at Bellevue or Cook County or the Vanderbilt Clinic or the Central Free Dispensary, he is generally convinced that what he gets is inferior to the care that is provided in Park Avenue consulting rooms and the top floor at Passavant Hospital. I submit that this conviction is a greater threat to the security of our private, voluntary medical and hospital system today than any evil plot that is being hatched in Moscow or Washington, and it can't be dispelled by mere publicity technics, no matter how clever or inspired they may be. It can't be dispelled, for example, by printing and distributing 50,000 or 100,000 copies of a picture showing a doctor sitting at the bedside of a sick child. It's a beautiful picture, all right, and it's symbolic of a beautiful relationship, but to the sick man at Bellevue it's just a picture. His doctor is not a patient man who sits beside him through the night but the impresario of a huge act whose chorus includes an awe-inspiring number of interns, residents, technicians, nurses, students and visiting medical dignitaries from South America. The most furious fulminations about the wickedness of "assembly-line medicine" under government control are not going to impress people whom the phrase strikes as an apt description of what they're getting today under private control.

If we can't dispel the poor man's conviction that his medical care is inferior by pictures, slogans and other devices of publicity or public relations technic, how can we dispel it? Under the circumstances, the only thing I can think of to do about this conviction is to remove it as far as we possibly can from its present painful proximity to the truth. The way to eliminate the feeling that the general practitioner is not as good as the specialist is not just to talk about how wonderful and skillful and devoted and energetic the general practitioner is already but also to give him more knowledge and more skill and better tools to work with. The only way to diminish the feeling that ward care isn't as good as private room care is to make certain that it is as good, remembering that medical care always includes attention to the patient's psychic as well as his physical needs. These things cut deep into the economics of our private practice and voluntary hospital system. As long as the rewards of specialty practice offer the physician so much more than general practice does, the more energetic and skillful men will tend to be attracted to the specialties; they will continue to earn large fees and drive Cadillacs and command the respect of society, and the disproportions that threaten the system will be prolonged.

Medical and hospital groups should be doing something about this besides gold medal awards and pictures and mottoes and pamphlets and publicity kits and canned speeches about socialized medicine. They could better be devoting their efforts wholeheartedly to the thoughtful, wholesome steps that are being taken toward eliminating the threatening disproportion. These steps include the development of general practice sections on hospital staffs and postgraduate training programs for general practitioners. The development of well rounded outpatient services at all hospitals would help tremendously, too, and so would the encouragement and expansion of group practice—especially in combination with prepayment. Hospitals that are built with broadly contrasting physical facilities for private and ward patients will serve the system badly as the years pass. So will hospitals that are operated exclusively for public charges and bar private patients, and hospitals that are operated exclusively for private patients and bar public charges. So will hospitals built and operated exclusively for veterans of military services. Hospital rate structures that load private room charges to cover costs that are hidden elsewhere also emphasize a weakness, because we shall probably never eliminate entirely the thoroughly American belief that you get what you pay for in this world.

IN RESPONSE TO DEMAND

These and other changes that are needed to strengthen the system won't come spontaneously. They will come only in response to recognition of need and demand for change. Like an inadequate doctor who tries to ameliorate the symptoms without understanding or treating the cause, a public relations effort aimed at minimizing or concealing the weaknesses of the voluntary health service system must ultimately fail, because it will permit the weakness, like the unrecognized malignant disease, to grow in darkness and destroy healthy tissue. The function of public relations is to illuminate the truth. Our voluntary health service system is good enough and strong

enough to survive public knowledge of its weaknesses and failures as a necessary forerunner to its improvement. But it is not strong enough to survive without improvement — no system ever has been or ever will be —and improvement is impossible so long as we devote all our energies to glorifying and magnifying our accomplishments and denying that weaknesses exist. Precisely the same thing is true of political democracy and economic capitalism. We shall never strengthen or preserve our system by putting ads in newspapers and magazines telling one another how wonderful it is, nor by condemning all its critics as Socialists. We shall preserve it only so long as we continue to make it work as well as we say it works and think it can work, and only so long as we continue to improve it. And we shall improve it only so long as we continue to illuminate the truth about its weaknesses as well as its strengths.

The professional and public relations people and others who devote their time and talents to noisy defense of the *status quo* and castigation of its critics remind me of the famous allegory of the cave in Plato's *Republic*. In the allegory, Plato postulated a society whose members lay inside a cave, chained so they could face in only one direction, looking at a blank wall. Behind them was a fire that threw its light on the wall, and between them and the fire moved a constant procession of people and animals and objects, throwing their shadows on the wall of the cave. In time, the people who lay chained in the cave learned to recognize these shadows. This shadow they called man and that one woman. This was a horse, that a camel. The long, thin shadow one man carried was a spear; the moving thing in that woman's arms was a baby, and so on.

Suppose a member of this society were released from his chains and led outside the cave, Plato suggested. Suppose he were shown real men and women and spears and babies and camels and horses? Suppose he were led onto a hilltop and shown the true source of light—the sun, then returned to the cave and chained again so he could see only the wall and the shadows? As he tried to describe his experiences to his companions, and urged them to break their chains, you can imagine what they would think. "This man is a dangerous radical," they would tell one another. "He obviously doesn't appreciate the advantages of Our Way of Life. He is stirring up discontent. He must be suppressed!"

Critics of our society, and our medical care system, today risk similar treatment at the hands of those who lie chained in the caves of prejudice, ignorance and smugness. Trying to show that what we think is truth may be only shadow, the critic may be called a radical and a leftist, and every effort will be made to discredit him. Yet the fact is that he offers society its only real hope of breaking its chains, for as long as people are perfectly content with their shadow-world they will make no effort to improve it.

The real function of public relations, as I conceive it, in the medical and hospital fields and in the world at large, is to help substitute substance for shadow, to help show what is wrong as well as what is right with the world, so that what is wrong may be made right and what is right may be made better. To do this takes far more than the cleverness of the publicity man. It takes the wisdom to judge between right and wrong and the courage to speak up against what is wrong, even when speaking up is as unpopular as it is today. Our professional groups and their public relations advisers must have that wisdom and that courage. If we don't get the truth from them, we aren't likely to get it at all.

Psychotherapy in General Practice

DR. LEO ALEXANDER, in the Oct. 6, 1949 issue of the *New England Journal of Medicine*, has written an interesting article on the use of psychotherapy in general practice. He says that such practice should not be limited to the specialist's office. In practicing psychotherapy, the author continues, it is important for the doctor to be careful of his attitude and actions toward the patient; how he listens and how he speaks to him are often more important than what he tells him. The most important psychotherapeutic technics are:

1. *Supportive Treatment.* The main element of supportive treatment is the doctor's attitude. He must demonstrate that he is interested and eager to help, by doing a complete physical examination and thorough history of the patient. He must maintain an open mind and be interested in hearing the patient's story.

2. *Ventilation.* The patient should be given a full opportunity to express his emotions and stresses in a setting of understanding approval. There should be little interruption and as much encouragement as possible on the part of the physician. Ventilation proceeding on an intellectual level is not always beneficial and it is necessary to bring about emotional participation as well on the part of the patient.

3. *Shift of Emphasis.* By this is meant the shift from the apparent complaint or conflict to the more important basic material that the patient offers without being conscious of having offered it.

4. *Interpretation.* This requires the greatest amount of skill, tact and timing. It is a process of understanding and must have the continued cooperation of the doctor and the patient. Interpretation must be in terms acceptable to the patient and a genuine understanding of the patient as a prerequisite.

5. *Reassurance.* It is essential that the patient believe that the doctor has been truthful. There must be a thoroughly warm understanding of the patient and the doctor must have a knowledge of his emotional needs.

The author favors giving the patient a true diagnosis in encouraging terms and instilling a feeling that the patient can do something for himself.

The author offers the following for those who practice psychotherapy in the office:

1. A warm supporting attitude toward the patient is a necessity.

2. The physician should not interpret unless he is really sure of his ground.

3. If the patient improves by becoming too dependent on the therapist, he should be referred to a person with more skill and experience in the field of psychiatry. Dependence is really regression, and although sometimes necessary in the treatment, it should only be a transitory stage.

4. The primary goal of psychiatry must be kept in mind—to help patients to health, happiness, maturity and independence. The patient must be helped to help himself. — IRVING GOTTSEGEN.

APPENDIX A

Safeguards Hospital Construction Standards

ISADORE ROSENFIELD
Architect
Hospital Consultant
New York City

IN A recent article in one of our hospital journals an anonymous authority is quoted as saying that "The unit cost of hospitals built with federal aid *will* (italics are mine) exceed those constructed with private funds because of the minimum standards which must be met." Similar assertions have also been made orally from time to time. If such statements were to multiply and gain general credence they would do damage to the public interest in direct proportion to their falsity.

I do not intend to fathom the motives for such assertions. I only wish to deal with their validity. The questions are:

1. Are the standards under Public Law 725 unreasonable?
2. What would be the consequences if the standards were lowered or abandoned?
3. Is there any evidence that federally aided hospitals are more costly than those not so aided?

REQUIREMENTS ARE REASONABLE

The requirements under Law 725 are quite reasonable. They are part of the tool kit of practically every American achitect and hospital administrator; and my correspondence, which extends to many parts of the world, shows that hospital planners all over the world are guided by these standards. It is the only reasonable set of standards that exists, and which can be used as a guidepost or a point of departure. As a matter of fact the standards are flexible; while most requirements are mandatory, a great many are "desirable but not mandatory." In any specific case where the standards would create incongruities with local customs, laws or climatic and other valid conditions, permission to make departures can be easily arranged for. The responsibility of departure from the recommended requirements as distinguished from the mandatory requirements rests entirely with the individual community and not with the federal agency.

My observations are based on experience in actual application of the standards in the planning of specific projects. I also have wide contact with the hospital planning world and I never heard anything but praise of the standards except from an occasional individual whose judgment is motivated more by prejudice against anything governmental than by sober consideration.

It is a curious phenomenon that persons who express themselves unfavorably generally fail to do it in the open, as is evident from the anonymity of the authority who is quoted in the unsigned article first referred to above. When they do make their objections in the open, they are vague in substantiating their charges. Such individuals usually fail to state which specific provisions are objectionable and why. They also fail to state what they would substitute or how they would modify the existing standards. No standards are perfect and these have already undergone changes where experience showed the desirability of such changes.

The present standards and regulations do establish a level below which a hospital could not sink. All reasonable students of hospital planning will agree that to go below the minimum requirements would produce either fire traps (remember Effingham!) or boarding houses lacking in the essential diagnostic and therapeutic facilities, or both. I venture to assert that the recent disastrous hospital fires which consumed lives by the dozen instead of restoring them to health could not occur in hospitals built in compliance with the standards under Public Law 725. An institution which lacks the essential diagnostic and therapeutic facilities is not a hospital, but a boarding house of the type employed by unscrupulous practitioners for the exploitation of innocent people. This is the kind of "hospital" which fails to qualify under the standards of the American College of Surgeons; this is the kind of hospital which to a great degree accounts for the hundreds of thousands of beds found to be "unacceptable" by the several states and territories in the surveys made pursuant to Law 725 and subsequent state authority.

ENSURES WORTHY HOSPITAL

No one is compelled to comply with the provisions under Law 725 unless he wishes to make use of federal aid. This federal aid not only makes it possible to have a hospital where it otherwise would have been impossible to build one; it also assures the community that the funds will be invested to create an instrumentality worthy of the name of hospital. Without the standards of Law 725, local sharpers or unwitting innocents would perpetrate boarding houses, or fire traps or worse.

The positive statement that federally aided hospitals *will* cost more than those not so aided is also unjust to most of the latter. The logical implication in such a statement is that were it not for the fact that communities have to comply with the minimum standards, they would build hospitals with low standards or perhaps without standards. Such things have happened and are continuing to happen, but it is unjust to give the impression that decent standards irk the average American community or that communities would generally wish to circumvent the standards if they could.

Now, is there evidence that non-federally financed hospitals *will* be

cheaper than federally financed hospitals? The facts in my experience show that there is *no* basis for such belief.

The April issue of the journal, *"Hospitals,"* gives cost data for nine federally aided hospitals under Public Law 725. These data are compiled in the accompanying table. They show that the average cost per bed of these hospitals is $13,775, the highest cost being $16,188 and the lowest $10,655. Conceivably someone has built, or could build, a hospital for less, but anyone familiar with current hospital construction costs knows that the foregoing figures are definitely low and reasonable. The cubic feet per bed are entirely reasonable and the average cost per cubic foot ($1.45) is considerably lower than we have been accustomed to in the postwar era. Even the highest cost in the table, $1.70, was reasonable when the bids were taken.

August, 1949

COST ANALYSIS OF HILL-BURTON ACT HOSPITALS
REPORTED IN "HOSPITALS," APRIL 1949

Hospital	State	Beds	Total Cost	Cost Per Bed	Cubage Per Bed	Cost Per Cu. Ft.	Cost Per Sq. Ft.	Rooms with Toilets	Laundry	Day Rooms
1. Goliad County Hospital	Texas	13	$ 158,000	$12,153	8,211	$1.48	$17.37	Some	No	No
2. Harrison County Hospital	Ind.	18	291,392	16,188	12,847	1.26	13.26	Some	No	No
3. Uintah County Hospital	Utah	30	421,408	14,047	13,378	1.05	14.12	No	Yes	No
4. Fayette County Hospital	Ohio	45	611,500	13,500	8,133	1.66	22.95	No	Yes	Yes
5. Lawrence County Memorial Hospital	Ill.	50	765,306	15,906	10,004	1.59	19.50	Yes	Yes	Yes
6. Clay County Hospital	Ill.	50	724,000	14,480	8,826	1.64	16.79	Some	No	No
7. Kerbs Memorial Hospital	Va.	68	1,080,640	14,715	8,656	1.70	21.20	No/Yes	No	Inadequate
8. Caldwell Memorial Hospital	Idaho	75	799,170	10,655	8,733	1.22	15.35	No	No	No
9. St. Francis Hospital	Ga.	150	1,600,000	12,317	7,663	1.61	18.75	Yes	Yes	No
AVERAGES				$13,775	9,714	$1.45	$17.69			

**"Hospitals" is the official organ of the American Hospital Association. Above table prepared by Isadore Rosenfield, Architect - Hospital Consultant.

I have designed a few hospitals under Law 725. For the 800 bed Tuberculosis Hospital in Puerto Rico (where hospital construction costs are high owing to the fact that practically everything outside of sand and gravel has to be brought over from the continent), the cost per cubic foot (November 1948 at the height of the construction market) was about $1.73, the cubage per bed was 3171 and the cost per bed about $5486. This hospital has first-class diagnostic, therapeutic and service facilities not only for itself, but, in addition, for 800 existing beds; otherwise the cost per bed would have been even lower.

This is a remarkable demonstration that under Law 725 standards one can plan so as to reduce the cost per bed to a very low figure even in spite of a rather high cost per cubic foot, and, as I explained, the high cost per cubic foot in this case is due to the peculiar situation of Puerto Rico and not to the standards under Law 725.

The Industrial Hospital for Puerto Rico (500 beds) is planned on a somewhat higher standard, but also in compliance with Law 725. It, incidentally, contains a large rehabilitation center, a 100 bed dormitory for ambulant patients, and an extensive outpatient department. Bids for this hospital had not yet been taken. It is going to cost less per cubic foot than the Tuberculosis Hospital because prices have come down since November 1948. But, assuming the same price per cubic foot of $1.73 as for the Tuberculosis Hospital, in this hospital (3608 cubic feet per bed) the cost per bed would be $6242. This is another clear demonstration that the standards of requirements under Law 725 do not impose a high cost upon the community.

On the other hand, let me give figures for a few hospitals which were not planned to comply with requirements under Law 725, which I planned in the past few years.

1. The Great Neck General Hospital (150 beds) has 8315 cubic feet per bed. It is expected to cost about $1.75 per cubic foot. At this rate it would cost about $14,550 per bed.

2. The Beth Israel Hospital in Passaic, N.J., (109 beds) has 8820 cubic feet per bed, is also expected to cost about $1.75 per cubic foot and should therefore come to about $15,435 per bed.

3. The Dearborn General Hospital, Dearborn, Mich., (200 beds) has 9465 cubic feet per bed, is also expected to cost $1.75 per cubic foot and would therefore cost about $16,563 per bed. This project includes a residence for staff, an extensive outpatient department, public health facilities, and a separate steam plant - laundry - and-garage building.

4. Recently I received bids for the Beth-El Hospital (a 128 bed addition to an existing 200 bed hospital in Brooklyn, N.Y.). This project consists, in addition to the new patient building, of a new outpatient department-kitchen-and-dining room wing, new power plant-garage and many and various alterations in the existing hospital. Because of the many alterations it is not possible to arrive at a cost per cubic foot. The cost per bed is $15,625. This again is not cheaper than the average for the federally aided hospitals.

The next two examples show that nonfederally aided hospitals can cost a great deal per bed. Thus the general hospital (222 beds) planned by a colleague in Detroit is reported to cost (pursuant to actual bids) about $1.83 per cubic foot, requiring about 18,000 cubic feet per bed which would involve a cost of about $24,800 per bed. Law 725 had not a thing to do with this project.

The *New York World Telegram* reported in February 1949 that bids taken on the Beekman-Downtown Hospital came to $32,000 per bed.

I do not mean to imply that nonfederally aided hospitals *will* cost more than federally aided hospitals. That would be as absurd as claiming the opposite. What it does mean is that hospitals which are sufficiently well off not to require federal aid frequently plan on standards which are far above those required by Law 725.

To recapitulate, my knowledge of the subject, as substantiated by the concrete figures given, shows that federally aided hospitals can be made very low in cost, that their average cost is low and reasonable; that the cost of nonfederally aided hospital projects is generally near the upper limits of federally aided projects and frequently exceed by far the average cost of federally aided projects.

Perspective sketch of the front elevation of the new 12 story building.

CHILDRENS HOSPITAL IS GROWING UP

HENRY N. WALLACE
Administrator, Childrens Hospital Society
Los Angeles

CLIMAXING a half century of service to the youth of Southern California, the Childrens Hospital Society of Los Angeles is planning the construction of a new building and the remodeling of its existing facilities.

"The hospital has experienced a constant growth since its foundation in 1901," states Mrs. Kate P. Crutcher, chairman of the expansion program committee and for 39 years president of the society. "Today the hospital contains 203 beds. It is a monument to the public spirited citizens of Los Angeles. It is a haven for the sick and injured and underprivileged children of our community. The present hospital was built to meet the needs of the population of 1930, however. Today we are struggling to meet the requirements of a population which has practically doubled since that time. Not a day goes by that a bed must be denied to some child in need. We are now determined to build a new hospital, one which will be adequate for our rapidly growing community."

The Childrens Hospital, located at Sunset Boulevard and Vermont Avenue, is a nationally recognized center of pediatric learning and of the treatment of the various diseases afflicting children and infants. It is a community voluntary institution, supported solely by private donations, income from part-pay and private patients and by the Community Chest. It accepts children up to 15 years of age without reference to race, creed, color or ability to pay.

Following a survey and report of the existing plant made several years ago, Earl Heitschmidt and Charles O. Matcham, Los Angeles architects, were recently commissioned to prepare preliminary sketches for a new building which will be a complete hospital in itself of 300 beds. It will be located on a site approximately 250 feet square, flanked on the west by the present nurses' home and on the east by the existing hospital building which, upon completion of the new structure, will be converted into cardiac and convalescent wards and quarters for interns and resident physicians, medical offices and complete teaching facilities.

The architects have prepared a long-range master plan which contemplates the construction of additional buildings to house these facilities when the present structure becomes outmoded and is finally demolished. The final result will be a completely up-to-date institution, modern not only in architectural aspect but in every phase of equipment and of methods of operation and teaching.

The immediately contemplated new building, for which the drive for funds has already been launched, will be 12 stories in height and of steel frame construction. Exterior walls will be of reinforced architectural concrete, with details of granite and limestone.

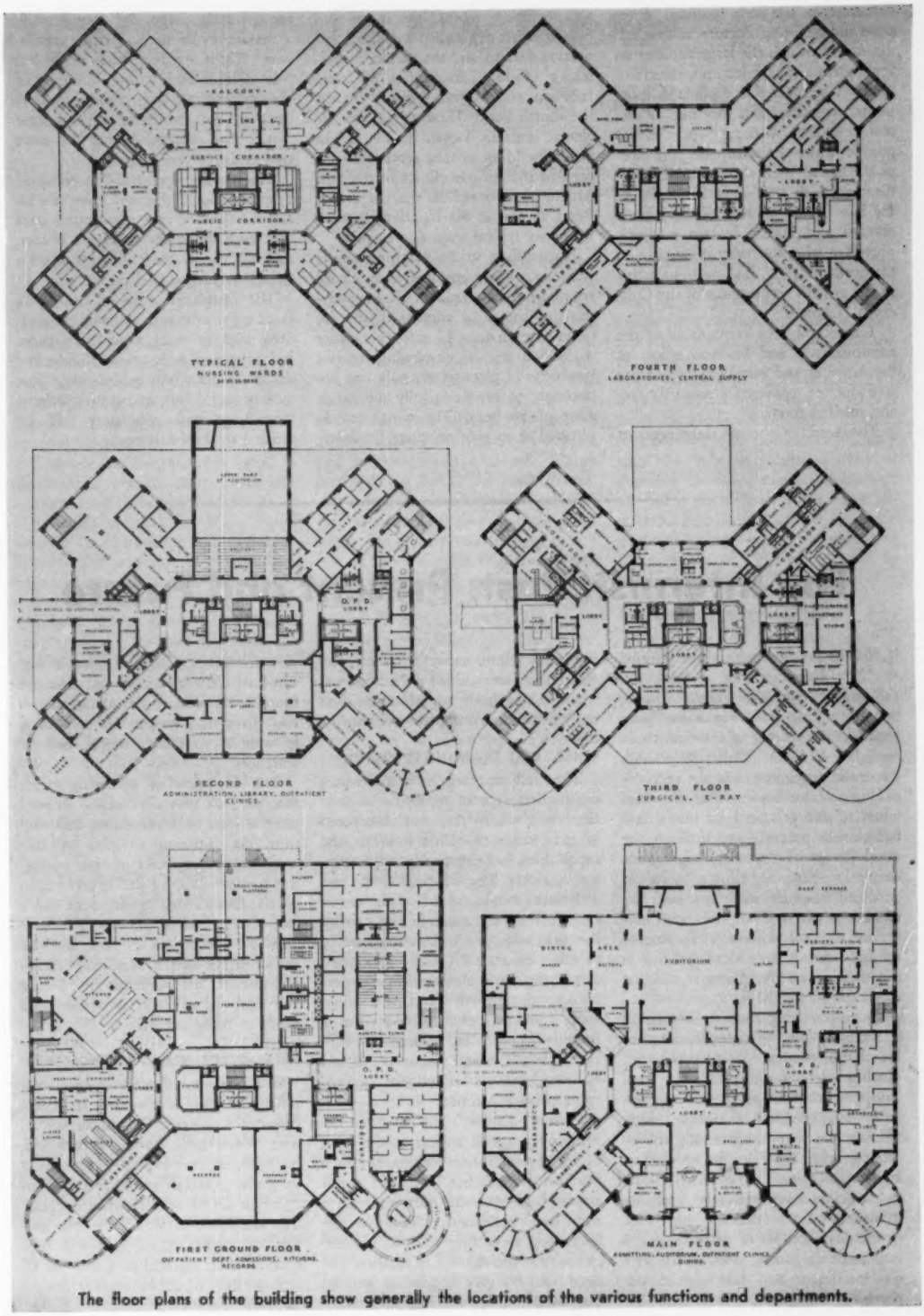
One of the most difficult problems met in preparing the long-range program was evolving a plan which would function properly in connection both with the existing old building and with future buildings which might have to operate while the old building still stands or after the old one is demolished. The architects have therefore adopted a plan which in hospital terminology is called the central core scheme. As the phrase expresses, the very center of the building contains elevators, service stairways, air conditioning and heating ducts, toilet rooms, nurses' stations, and the principal circulatory public corridors. On the outside perimeter of this corridor are located the various functions, rooms and departments of the working hospital.

SERVICES ON GROUND FLOOR

The ground floor contains the building services, staff doctors' and nurses' lounges, locker rooms and toilets, receiving entrance, kitchens and storage rooms, employes' quarters, record storage rooms, pharmacy, the admitting section of the outpatient department and its connecting large student clinic.

The outpatient department is the largest and one of the most important single functions of the hospital. It occupies the entire west one-third of the building; its dozen or more clinics rise through three floors; it then connects directly with the two floors immediately above containing x-ray, therapy, photographic and laboratory departments with which the outpatient department is closely associated.

The main floor contains the public entrances, lobbies and waiting rooms, the hospital admissions and emergency



The floor plans of the building show generally the locations of the various functions and departments.

departments, the soda fountain, drugstore and gift shop, doctors' and nurses' dining rooms and the large auditorium for student and staff lectures, entertainments for staff and ambulant inpatients, receptions and meetings of the many social, working and service groups which help support the hospital. There will also be an amphitheater which will be a memorial to the late Dr. Hugh K. Berkeley, much revered and widely known pediatric physician who, for many years prior to his death in 1947, had been so active in the growth and services of the Childrens Hospital.

The second floor contains all of the administrative and business offices of the hospital and here are located the staff doctors' conference room, library and reading room.

The third floor houses the surgery of six operating rooms, the x-ray and photographic departments in close connection thereto, and the various appurtenant offices. Laboratories of every function and central supplies occupy the fourth floor. These two floors are almost centrally located in the height of the building as they serve the children in the various clinics of the outpatient department in the three first floors as well as the inpatients housed in the six typical ward floors above.

Outstanding in the planning of the typical floor is a teaching and demonstration room for student classes studying the disease or ailment of the patients on each floor. Nurses' stations are so located that by employing interior partitions of glass panels only two are necessary to supervise fully the entire floor of 56 beds. The wings are so planned as to give adequate flexibility for changing usage, and they provide a maximum of natural cross ventilation. Wards are planned to house but four children each with a minimum of one-bed and two-bed rooms, indicative even to the family of very meager means that every child has the same care as the private patient.

The top floor penthouse is occupied by occupational therapy. Here are located a half dozen playrooms, craft and work shops, the children's library, and roof decks for outdoor sunbaths, classes, recreation and play.

The decorative style of the entire building will be such as to fill the children with as much confidence, cheer and happiness as is possible under the circumstances. Pretty wallpapers, comic murals, gay colors in painting effects, furnishings and upholstery will be utilized to their full extent.

The Internist: Past, Present and Future

IN HIS presidential address entitled "The Internist, Past, Present and Future," to the 30th annual session, American College of Physicians, published in the *Annals of Internal Medicine,* July 1949, Dr. Walter W. Palmer traces the development of the specialty of internal medicine, from the days when it was practiced by but a few fashionable practitioners through the development of the many high grade university medical clinics, privately endowed research institutes, and the affiliations of large hospitals with university medical schools. He stresses the influence of these developments in the training of the internist and the elevation of standards.

By emphasizing training in clinical science, selecting patients because of the disease under special study, employing elaborate methods in well equipped laboratories to study underlying derangements of disease, using animals for experimentation, collaborating with chemists, bacteriologists and physiologists, the university clinics in particular have had a far reaching influence. Such technics have led to the development of more than 100 important diagnostic tests, along with the intelligent and safe use of important therapeutic measures. At the same time, however, these developments have added difficulties and complexities both to education and to the sound practice of medicine.

WHERE BEST TRAINING IS FOUND

The best training is found where the highest type of medicine is practiced and where the staff, composed of individuals of varied interests and capabilities, has engaged in active clinical research. The full-time chiefs and assistants should spend their entire time in teaching, research and care of the sick without the interruptions of private practice. Close association should be maintained with the preclinical departments and the house staff, and such men should form a functional unit, in association with the occasional researcher who can add the wisdom and experience derived from private practice.

Present danger signs in this developing program appear in the form of insufficient funds, forcing key men into private practice. Research funds are available for the most part on a short-term basis and may prove embarrassing since they tend to increase quantity at the sacrifice of quality. The need today is for funds for general purposes. Finally, the large sums available for investigation of specific diseases to elaborate and well financed foundations tend to drain the university clinic and hospital of key men, as well as to attract unqualified researchers.

The depletion of operating funds through lack of endowments, reduced interest rates on investments, and wartime tax inflation suggests government funds as a source to meet operating needs. Despite the apprehension of universities that government funds may lead to loss of control, there have been no complaints to date, and the author urges that a National Science Foundation, as projected in Senate Bill 247, would make available fluid funds so badly needed.

WILL AFFECT MEDICAL PROGRESS

The problem of medical care, centered on the distribution of costs, presents a powerful but uncertain influence and must not be approached, he feels, at the expense of medical progress. Careful study is urged in order to arrive at a satisfactory plan. The direction in which the distribution of medical costs goes will profoundly affect medical progress.—E. D. ROSENFELD, M.D., *Montefiore Hospital, New York City.*

The Floor Secretary Is Here to Stay

ELLSWORTH T. NEUMANN, M.D
Assistant Director, Massachusetts General Hospital, Boston

THE floor secretary is in the hospital to stay. She is in a unique position by virtue of being both needed and welcomed by the other members of the hospital team.

The need for the floor secretary has been brought about by the continuance of several long-standing trends in professional nursing, special services and medical records.

The relevant long-standing trend in professional nursing in the voluntary hospital may be summarized briefly as a growing demand for floor nurses steadily outdistancing the available supply. The demand for floor nurses increases rapidly as professional and public opinion sets increasingly high standards on the amount and type of nursing needed by the bed patient.

The availability is reduced by the diversion of floor nurses from voluntary hospitals into similar activities in federal hospitals, into public health nursing, into industrial nursing, and into private duty nursing.

The situation resulting inevitably from this trend is that there are too few floor nurses to do the floor nursing required.

TOO MUCH DESK WORK

Coupled with this situation is the trend for the floor nurse's time to be taken up by her desk work to a greater extent with each passing year. Greater administrative control has produced an overwhelming number of administrative forms to be completed—often in duplicate or triplicate. Forms must be filled in for the admitting office, the information desk, the administration office, the nursing director's office, the pharmacy, the engineer's office, the housekeeping office, the comptroller's office, the medical record department, and the laundry. Accuracy, legibility and completeness on each form are essential. Failure on any one of the three counts produces the same effect as a monkey wrench dropped into a complicated machine. To avoid censure, a nurse on each floor must chain herself to the desk for a large portion of the day.

In addition to these trends in nursing, there are aggravating trends in the keeping of medical records. A medical record department is no longer a room in which charts are hastily filed and forgotten. It has now become a veritable beehive of activity. The greater appreciation of the value of complete and accurate medical records, higher standards set by professional groups, vast increases in health and accident insurance, and routine summaries to physicians or hospitals referring or following the patient have produced this effect. Charts are completely revamped and checked minutely before the real work is even begun.

Improperly placed or missing reports slow the processing and start a chain of reactions which may begin with an impatient telephone call and end with a search of the nursing station by one of the record department personnel. The enforced haste on the part of the floor nurse thus means loss of time in the medical record department and, occasionally, if the lost report is not found, financial embarrassment to the hospital and the patient when proof is lacking on which to base claims in court or insurance procedures.

Another trend which sharpens the effect of each of the preceding trends is the result of more scientific medicine —the vast increase in requests for special services and diagnostic tests. What were once special diagnostic procedures are now almost routine diagnostic procedures. Indeed, the special service departments might be more aptly named the routine service departments.

Yet on each test or service listed on the doctor's order sheet, a nurse must perform an individual task before and after its completion. Should she write hastily with a semilegible or illegible hand, the task will probably be done, but the report will not reach her desk on its return. Should she not place it properly and immediately in the chart, the doctor will not see it. The result will be a repeated request, which means poor medical care and a financial and time loss to the hospital and the patient.

For all these trends there must be a counteracting force. Nursing schools are doing a magnificent job in training a greater number of nurses to help meet the increasing demand from all quarters. However, those trends which are based on a desire for greater administrative control, more scientific medicine, more nearly accurate and complete medical charts will not be purposely reversed.

USE UNSKILLED PERSONNEL

Other solutions have been put into effect with success. More untrained employes have been added to the floors to do the totally unskilled jobs involved in housekeeping, carrying of trays, and so on. Practical nurses have also been added in many hospitals to do the simpler nursing procedures. Where they have been used, they have done their job most successfully. However, this latter solution has inadequacies in that the number of practical nurses is insufficient to stem the tide, and one cannot reasonably assume that the number will meet the need in the near future.

In addition, it would appear to be poor logic to substitute a person with less training to fill the patient's nursing needs, while at the same time the comprehensively trained nurse is forced to spend her time doing clerical work and performing a multitude of minor administrative tasks which could easily be done by an intelligent person with a few weeks of training.

For reasons of logic plus an insufficient number of practical nurses, the most nearly adequate solution becomes the use of floor secretaries. The advantages lie in several directions: (1) the training period for floor secretaries is only a fraction of the time necessary to train registered and prac-

tical nurses; (2) people to fill the job successfuly can be obtained in unlimited numbers because other than the qualifications of a high school education, intelligence and an ability to write legibly, no technical training requirements are necessary; (3) the salary of a clerical worker is lower than that of either a practical nurse or registered nurse, and (4) there is a financial and time saving in that the work is more nearly accurate, complete and legible than when it is done by a nurse whose main interest must naturally be the nursing care of her patients.

NURSES WELCOME THEM

However, these are not the only reasons the use of floor secretaries is a good solution. In addition to the fact that they fill a definite need and produce a financial saving in several ways, they are indeed welcomed by the floor nurses. This is a most important factor. Without it, the use of floor secretaries would mean a far less satisfactory solution. Probably the factors which induce a hearty welcome are based on the general opinion of nurses that (1) ward secretaries not only cause no lowering of the general level of nursing standards but tend rather to raise it by freeing the floor nurse for more bedside nursing, and (2) ward secretaries are not actually doing nursing functions but only the clerical work which has been the necessary evil attached to the real work of nursing care.

Thus is explained the need for the floor secretary and the welcome given her. It does not provide, however, a job analysis, a description of the preliminary training or the personal qualifications necessary to fill the job.

It is not expected that the description of duties, training or qualifications would embrace the exact needs of every hospital or the ideas of every director of nurses. They are listed rather as basic descriptions to which more may be added or parts subtracted.

The individual qualifications of a prospective floor secretary have already been listed as a high school education, good intelligence, and a legible hand. It is desirable to select those who appear to be quiet and emotionally stable. Those who are between the ages of 25 and 40 years appear to have the greatest degree of success. Previous secretarial or clerical training is by no means a necessity.

A job analysis for the floor secretary on the week day would be approximately as follows. Duties to be accomplished at certain hours are:

8:30—9:30 a.m.

1. Check needs and fill out order forms for the following:
   - Central supply equipment
   - Laboratory supplies
   - General store supplies
   - Linens (Note: Head nurse should designate the standard requirements of the floor for all supplies)
2. Fill out daily time slip for office of director of nursing.
3. Fill out such forms as may be used chiefly as financial data rather than medical information, e.g. list of patients receiving penicillin and the amounts received on previous day.

9:30—11 a.m.

1. Chart all temperatures from temperature book.
2. Insert laboratory reports in charts.
3. Check diet list or diet cards or menus in accordance with usage. Recopy whatever is necessary.
4. Keep desk drawers clean and equipped with necessary supplies.
5. Rule and date temperature books and medical order books.

11—12:30 p.m.

1. Receive pharmacy supplies and check immediately for accurate and complete filling of order.
2. Receive and check general store supplies.

12:30—1 p.m.

Lunch

1—4:30 p.m.

1. Chart temperatures which have been taken at noon.
2. Check chart racks for old charts or charts of discharged patients and return to record room.
3. Fill out patients' condition sheets in duplicate for information desk and nursing office.
4. Check order sheets and fill in requisition forms for the following day's tests and treatments in special service departments.
5. Make out temperature book for next day.

Duties to be performed during the day whenever necessary are:

1. Answer telephones and take messages when nurse is not near desk. (However, at no time accept a verbal order for medication over the telephone even when the nurse is not present.)
2. Notify floor aides when patients are to go to x-ray department and note completion of x-ray test on order sheet.
3. Respond to patient's signal when no nurse or aide is present and inform nurse or aide of patient's request.
4. Receive visitors and take them to bed of patient.
5. Receive, sign for, and deliver flowers, packages and mail delivered to floor.
6. Watch tube system and prevent tie-up of unused tubes.
7. Fill in emergency work orders.
8. Notify the nurse of the presence of attending physicians.
9. Help in the admission of patients; *i.e.* show patient to proper bed, introduce him to other patients if possible, acquaint him with some of the hospital routines, and fill in proper notification forms.

The proper performance of these duties keeps a floor secretary quite adequately occupied throughout the entire day. In fact, unless some preliminary orientation is done, the incoming and untrained floor secretary is overwhelmed by the diversity of duties to be performed.

When the floor secretary system is installed, it is therefore advisable to devote two or three days to an orientation course before the secretaries are assigned to definite floors. This also allows a more suitable assignment in accordance with the personality and interests shown by the individual secretaries.

BEST ORIENTATION PROGRAM

The orientation period will be most successful if it is based on the following premises:

1. That the main effort in orientation is to show the trainees that the important and essential activities of the hospital are not limited to the floors on which they are to work but, rather, are spread throughout the hospital and carried on by a multitude of people in different trades and professions all working hard and under as difficult circumstances as those on the secretaries' particular floors. If this one idea is firmly established in the mind of each trainee, her future contacts with other departments and services will be marked with far more patience and equanimity than if she does not realize this.

2. That the secondary effort is to explain each requisition or report in the department in which it is most connected. In this way, the requisition or report may be seen in conjunction with the work involved in completing the requisition or report and the people who must do it, and thus the significance of each form becomes clear. In addition, the trainees become acquainted with the personalities, attitudes, feelings and prejudices of those to whom they must often telephone unusual requests.

A satisfactory plan for the orientation period is to supply each department head with the forms relating directly to his department, set a time during the tour in which the trainees will visit his department and receive instruction in the working of that department, as well as those points in the forms which the department head considers most important. At the time of instruction each trainee will be given a copy of the form under discussion.

The tour should take in almost every department in the hospital. It should be organized by the director of nursing or one of her assistants and should be arranged so that the visit is timed not with a period of relative inactivity but rather with a period of great activity.

The tour must at times go to the floors for extended instruction in various departments. The tour should end in the record room for a final summary and a discussion on the importance of accurate medical records.

One cannot expect that this instruction, given in a period of two or three days, will produce a group of floor secretaries ready to assume all the responsibilities previously listed. One can expect, however, that the training by the floor nurse will be made much easier by this establishment of values and acquaintance with hospital background.

With a short training period and the relative ease with which a hospital can obtain qualified personnel for the job, the setting up of a floor secretary system is not difficult. Provided a hospital has a need for floor secretaries, it can be assured of reaping financial gain and indirectly more nursing care for its patients. And when the floor secretary is established as an integral part of the floor team, she is in to stay.

The Things We Can Do

TO REDUCE PAY ROLL COSTS

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IN CONSIDERING labor saving and its resultant monetary saving there are two aspects—the problems of personnel and the arrangement of the physical plant in which the personnel must work. Because from 60 to 70 per cent of our hospital cost is in pay roll, it may be well to examine briefly the management of our personnel.

PERSONNEL

Since the war, hospitals have been able to use some discrimination in the selection of personnel. They have also been able to do some in-service training, but this has not been as complete and sustained as it should be. Most of us have personnel policies, but they are not always well stated or clear in our minds, and we are not always consistent in their application. Any hospital of 50 beds or over should know and use the various devices of personnel practice—job analysis, rating, description and specification. These will help us install an orderly framework of qualifications and salary scales. Interview technic should be improved, our labor turnover and the reasons for it should be known to us. Exit interviews, in-service training programs, and some sort of merit rating are tools which we should use to maintain efficiency and reduce our costs. It is expensive business to employ someone and have that person leave after a month or so.

Job analysis is simple. Each worker should note on a work sheet everything he does. With further questioning by department heads you will arrive at the content of each job and you will have started on your program. You will also have learned a considerable amount about what your employes do.

In formulating job descriptions, you will have an opportunity to allocate to workers the "twilight zones" of effort which tend to be everyone's business and no one's responsibility. You will find that there are workers who by reason of personality or years of service will be rated much more than the job should pay. The adjustment is a matter you will have to decide, but the decision will have to be made if you want to cut pay roll costs. We know that the unhappy worker is unproductive, but do we ferret out the causes of such dissatisfaction, and correct them? There should be a good two-way channel of communication so that these "gripes" and "suggestions" get action promptly. Too many good ideas of workers perish for lack of kindly, sympathetic action by top management.

Do we welcome our hospital employes with a good orientation program and consistent follow-up? This is not an attempt to lecture on personnel, but we *are* talking about labor saving and pay roll costs. The best way to cut these costs is to select the right type of worker, introduce him to his job properly, instruct him, maintain a healthy interest in him, get the most out of him in such a way that he likes to do it. All the mechanical devices in the world will not help if the personnel practice is slipshod.

The greatest lack in the hospital field at present seems to be good supervisory personnel. These employes should be selected not only for their technical knowledge but also for such traits as character, personality, integrity, loyalty, sincerity, tact, self-control, ability to make decisions, to carry responsibility, and to judge human capacity. They must understand, above all, that teamwork is the essence of the good hospital.

PHYSICAL PLANT

It is difficult completely to rearrange your physical plant, designed for another era, but small adjustments are possible. There should be a master plan that blueprints the way to an orderly program. Mere patching is wasteful, costly, time-consuming and disheartening. In such a master plan, we must plan for those lines of supply which are fundamental, namely, dietary, laundry, central supply, pharmacy, laboratory and x-ray. The use of dumbwaiters, conveyors, pneumatic tubes will assist us in decreasing labor costs. Let us agree at this time that an employe at $175 a month is not an economical means of transportation.

Front office procedures should be scrutinized. Machine bookkeeping, the elimination of unnecessary detail, the combination of duties will decrease the number of personnel in almost any hospital office. The admission procedure in most hospitals will bear review. A short time ago I saw a collated ad-

mitting form at $50 a thousand which obtained only the information required by the business office. Other departments, such as dietary, medical records, housekeeping and nursing floors, were all forgotten. The process or form used is unimportant as long as all departments obtain the information from the one period of questioning. The excellent work done by Dorothy Pellenz of Syracuse Hospital may well be used as reference.

Most small hospitals have medical record trouble. By having a sufficient amount of dictating apparatus so that night operations and deliveries will be ready for transcription by the librarian in the morning, many hours of filing and refiling and pressure on the doctors will be eliminated. If you are in a small community and the local doctors will standardize on one type of machine, they can send their transcriptions of physical examinations to the hospital with the patient. And speaking of records, perhaps no more untouched field lies before us than the periodic revision of all of our records and forms.

ICE PROBLEM SOLVED

The ice problem of the hospital is one that will bear investigation. The use of block ice with the attendant labor and mess is rapidly becoming obsolete. The new ice cubers and flakers are compact, clean and efficient. Flake ice can be used in the old oxygen tents if a basket is provided. The conventional ice bag can be abolished and alcohol and glycerin bags first installed at the California Hospital years ago can be substituted. Refrigerators with direct expansion coils are required. Vacuum water bottles, although expensive, will save many steps in the nursing department. The use of refrigerated oxygen tents is almost commonplace.

Laundries have made some of the greatest advances in labor saving devices. The self-dump washers, formula plate control, hydraulic extractors, crane lifts for extractor baskets, mechanical shakers for sheets and folders on mangles have cut down the usual 20 man laundry crew. In addition, proper bagging and sorting at source with conveyors and chutes have done much to save rehandling. Saving in the laundry is best started by good linen control methods. Linen usage should vary with the census and type of patient, not with normal bed complement. All linen should be weighed, as accurate cost and use factors are more easily determined in this way.

The boiler room is one of the departments which lends itself to savings —not by any new devices, but by the use of better materials in steam traps, washers, valves and so forth. The ingenuity of hospital engineers is well known, but we should inquire to see that we are not wasting good salary money on equipment which might better be surveyed. The small hospital, by the use of electric sterilizers, or sterilizers on a small high pressure 15 horse power boiler with full safety controls, may eliminate the salary of the afternoon and evening engineer. Likewise, a control clock regulating the boilers to low pressure after 5 p.m. may also effect savings in engineers' salaries. The hospital which does not have stack thermometers, draft gauges, and carbon dioxide testing apparatus on its boilers is sailing an uncharted sea as regards cost. Work request slips to the maintenance department should have sufficient information so that extra trips will be eliminated.

Standard layout of nursing floors enables better utilization of personnel and eliminates the problem of "groping" at first assignment. Staffing nursing floors with a required number of personnel and the use of a floater group of nurses for peak periods may result in some saving. The use of secretaries at nursing stations has proved effective. They perform routine duties well and enable nursing personnel to devote its time to nursing.

Trained nurse's aides are almost universally accepted, and their recruitment and control are problems that will be solved by intelligence, understanding and good supervision. The use of local school facilities for their didactic instruction should be explored, and there should be increased use of visual aids in their training. There is a need for sponsorship by the national and state hospital associations to make available good training films for hospital personnel.

The dietary department—one of the most important from the standpoints of both cost and patient satisfaction—is usually the last to be renovated. Good lighting and ventilation will increase the output of the workers. A rough flow chart may show many duplications and unnecessary motions. Consider the dishwashing equipment, install thermostatic controls, use prerinse washers which do not require individual handling of dishes, investigate the new pot washers, rotary gas ovens and steam cookers. Their purchase will repay you both in time saved and in less food shrinkage. With the use of vacuum food equipment we can have an individual central tray service. One hospital is transporting food in this manner about 10 miles and it is deliciously hot when it arrives. Improvement and use of this equipment may have a modifying influence on the overexpansion of floor pantries with their multiplicity of personnel.

The department of central supply has shown the greatest advance in line assembly technics, conservation of supplies, and better utilization of personnel. Rubber gloves are now washed and dried in home washers. Compressed air is used to test damaged gloves, and powdering is now done in a tumbler apparatus. All linen for surgery, maternity and nursery may be processed and sterilized in central supply. Metal snaps and tie tapes have speeded the packaging of supplies, and the use of kraft 40 and parchment paper has reduced the use of muslin and laundry. Mass preparation of intravenous tubing, sharpening needles and hypodermic syringe preparation have lightened the task of floor nurses and improved technic. Architects and consultants still need to be aware of the fact that the efficiency of the central supply is promoted or curtailed to the degree that conveyor or dumbwaiter transportation is made available to central supply and nursing stations.

PROTECTION FOR PATIENTS

Recovery rooms for patients are becoming almost commonplace. This concentration of equipment and personnel offers the best protection to the patient and also effects economies on the nursing floor. The installation of an oxygen system, while expensive, is justified on a long-term basis. Minimum planning will require this installation in nursery and recovery rooms.

There are no sure easy ways or devices to save costs. Keeping costs down is a disagreeable, monotonous day by day, in fact hour by hour, task. There is a tendency at times for people to want more for doing less. The only way to combat this is by a scientific vigorous approach which considers both personnel and physical plant arrangement. The good administrator will strive to take the backaches out of hospital work, the headaches out of his own and his associates' work, and the heartaches out of administration.

Architect's sketch of McCosker-Hershfield Cardiac Home.

Planned for the Comfort of Cardiac Patients

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THERE is an acute shortage of hospital beds. This is an indisputable fact. It is a condition constantly aggravated by the inadequacy of new construction and the continuing obsolescence of existing facilities. Even where complete plans for new construction are available, they are often shelved indefinitely because of prohibitively high building costs.

Under these conditions it is imperative to determine how best to utilize the beds in the existing medical-surgical hospitals. It is recognized by hospital authorities that much-needed beds for acutely ill patients are occupied by the chronically ill and by indigent convalescents unable to pay for private post-hospital care. The reason is that there are not enough specialized facilities for the proper care of these patients, although the type of accommodation and care they require is considerably less expensive than is that needed for acute patients. As uneconomical as it is, this situation persists.

Some measure of relief in the prevailing shortage of acute beds can be obtained by releasing as many of these as possible from occupancy by the chronics and convalescents. Moreover, continuing this condition is contrary to contemporary medical practice, since the average acute hospital is not geared to sound care of chronics or convalescents. In addition to the inefficiency, there is the wastefulness of diagnostic and therapeutic facilities, as well as specialized nursing care.

The project illustrated in this article was designed in association with Katz, Waisman, Stein and Weber, architects.

TWO-FOLD ADVANTAGE

The construction of special facilities for chronics and convalescents, at a very much lower cost per bed than that for acute beds, has two advantages: (1) the patient receives the proper type of medical care and rehabilitation, and (2) a great number of beds is released in existing facilities for acute patients, at a cost well below that now holding up the erection of new medical-surgical hospitals. Not enough emphasis can be placed upon these facts. While this in itself is not a solution to the acute bed shortage, it will relieve it and permit a more efficient use of present facilities.

Convalescents must not be returned prematurely to their home environment before they are fully restored to a normal community life. They must be given an opportunity for this recuperation in a home especially designed for it.

EXISTING PROTOTYPES

The nonsectarian McCosker-Hershfield Cardiac Home, while modest in size, is a most creditable example of such a facility. Although its present motto is "to provide cardiac convalescent care for needy adults," the needy or indigent are not the only ones who might benefit from a home of this type. On the contrary, it is widely recognized that such facilities are needed generally, not just by those unable to pay for their use. For heart disease is a national problem. Recent Congressional action brought the establishment of a National Heart Institute. This institute will be authorized to make grants of federal funds to agencies such as this home for work aimed at combating heart disease.

Under no circumstances should such homes be patterned along the disreputable "county poor house" lines. A sojourn in a convalescent home must not be associated with the stigma of destitution.

A convalescent cardiac adult is likely to return prematurely or ill advisedly to his normal occupation; this is more likely to happen when he is permitted to return home from the

hospital than when he has the opportunity to convalesce and readjust thoroughly under continued medical and specialist care in a cardiac home. There, it may be determined to retrain him for another occupation because his original work may be harmful. Such care may forestall his relapse and rehospitalization, with the attendant damage to himself and concomitant loss of hospital bed space. This must not be lost sight of in determining eligibility for admission in a specialized facility for cardiacs.

BASIC REQUISITES

The contemplated expansion of the McCosker-Hershfield Home for Cardiac Adults may well have application to other similar undertakings. Located in Hillburn, N.Y., the home is within reasonable proximity to good general hospital facilities in the adjacent town of Suffern. This is an important requisite as a close relationship can be maintained with medical authorities, and emergencies can be cared for promptly and efficiently. The distance from New York City, whence come most of the guests, is less than an hour by bus. It is short enough for the guests to receive visits from relatives and friends, and thus maintain the social contact so important to their well-being. Under these conditions it is less difficult to rehabilitate them and return them to their normal lives. Restoration to employment is a vital objective, as the capacity to earn and be useful socially provides a purpose in life.

Straddling the Ramapo River, the present site of approximately 12 acres offers many fine features conducive to rapid convalescence. West of the river the grounds are high and dry, with well cultivated lawns and beautiful trees. The easterly portion of the property, much larger in area than the westerly, is barely above flood level and is sparsely wooded. Its proximity to the railroad tracks and the smoke from the locomotives occasionally suspended over it are detrimental to its utilization. Because of these objectionable features, this acreage cannot be seriously considered for the new home. On the other hand, the lesser area across the river, though more suitable as a building site, imposes serious limits on the capacity of the new structure.

Although 150 to 200 guests would be desirable, not more than 100 can be properly accommodated on it. The reasons for this are obvious: the 3½ acres of high ground are already partly built upon and occupied by the existing home and the service building. While the remaining area is large enough for a multi-story building accommodating more than 200 occupants, such a structure would be inappropriate for the intended purpose. The structure should be neither a tall hotel-like building, nor a formal institution of the common prototype, but preferably a rambling, home-like architectural group, designed to preserve the present residential atmosphere conducive to restful recreation and relaxation. This would also retain and strengthen the intimate relationship of the buildings with the surrounding countryside.

ENVIRONMENT

Obviously, the restricted high grounds are inadequate for all the desirable outdoor passive recreation for both the guests and staff. Therefore, the scheme recognizes the potentialities inherent in the development of the low grounds east of the river into a park with ample walks, gardens and playgrounds.

The difference in levels of about 25 feet between the two sites would appear as a serious obstacle to the realization of such a long-range development. However, in the proposed structure, the elevators, essential for the intercommunication between the three levels of the building, are extended down to the cellar level, at which the service lines will be distributed. From this level a short underground passage could lead to the banks of the river at an elevation just above floor level, or almost level with the far bank. From here an inexpensive bridge can be thrown across the river. Prior to the eventual development of this park, the sloping west bank could be terraced and utilized for quiet relaxation.

The suggested new structure is placed to retain the advantages now enjoyed by the existing buildings, and the general informal character of the architecture is in harmony with the surroundings. The relatively small three-story cottages, grouped around the one connecting corridor, preclude the impression of institutionalism. Yet, from the point of view of administrative supervision and ease of maintenance, the entire ensemble is compact and all facilities can be reached without stepping out of doors.

TYPES OF BUILDING

This planning for cardiac convalescent care resulted from a comprehensive study and understanding of the many factors bearing upon it. It excluded discredited architectural monuments whose meaningless symmetry and wasteful circulatory plans were developed at the expense of improved facilities for the proper cure and social rehabilitation of the patients. Therefore, just following precedent and modifying it is not enough. It is imperative to study carefully all implications of cardiac convalescent care by consulting with the people concerned—patients, staff and certainly the medical specialists in this field.

The cardiac adult requires the restoration of his confidence in the future, occupational retraining, good home-like surroundings, proper diet, rest, recreation and medical care. These objectives must be kept in focus by the intelligent planner. Their realization must be achieved within the physical limitations of the structure, through ingenious methods which must also be economical in original cost and subsequent maintenance.

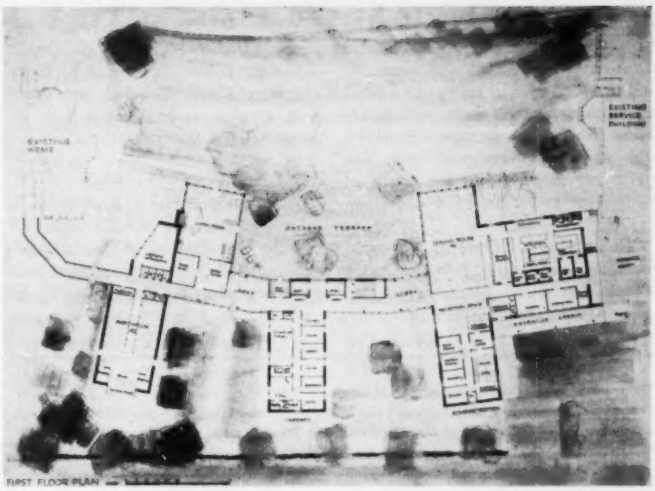
STAFF NEEDS

Caring for a hundred or so patients involves a number of additional staff members. Thus, the total population of the home becomes quite a community in itself. When all these people are concentrated on limited grounds, the danger of an institutional atmosphere must be avoided, and overcome where it exists. The various categories of personnel and guests call for appropriate zoning of the use of the grounds and buildings by controlling the indoor and outdoor activities of all in a definite yet unobtrusive manner. Further, since cardiacs should not be forced into undue walking, climbing or other physical efforts beyond the limits set by medical advisers, the essential zoning must be coupled with centralization of activities that will eliminate excessive physical strain.

Close relationship must be established between indoor and outdoor guest facilities, because of the beneficial effects of the enjoyment of fresh air and sunshine in the days of convalescence. For obvious reasons, no steps must impede the easy circulation of guests to and from the outdoors. Such an arrangement not only will encourage the cultivation of outdoor habits, but also will benefit the

occasional wheelchair case who, though not frequent, may be present and deserves consideration. At the same time, the absence of steps, with their attendant difficulties for cardiacs, frees the patient's mind from dwelling on his weakness and infirmity, and becomes a positive factor in his mental attitude toward his condition.

In addition to these basic considerations, the guests and staff must be protected from the hazards of vehicular traffic crossings, and the noises of deliveries and discharges. They must be screened from all disquieting activities, such as garbage disposal or the occasional dispatch of an ambulance to a hospital.



There is a close relationship between indoor and outdoor facilities.

CENTRALIZATION AND PRIVACY

For the proper functioning of the home, every activity must be located to be reached without passing through or disturbing any other activity. This suggests development based on cul-de-sacs. There must be a minimum of disturbances in the sleeping areas, with no through traffic. This type of planning, fortunately, dovetails with the idea proposed here for the small cottages grouped around one connecting corridor.

Broadly speaking, the accommodations for the guests fall into two major groupings: those for sleeping and those for daytime activities. Since the former are best placed when segregated from the latter, they have been located on the two upper floors, with intercommunication to the lower floor by means of elevators. This location of the bedrooms, chosen for the sake of quiet and privacy, is also most suitable for those confined to bed; the infirmary is also located at the end of one of the sleeping wings.

For a convalescent person, maximum privacy and quiet at night help speed recovery through restful sleep. In the case of cardiacs this point requires even greater emphasis than it does for other types of patients. Therefore, the basic plan here presented is predicated upon single rooms only. However, alternate schemes with combinations of single, double and multiple wards have been worked out for the sake of comparison. It should be remembered that the choice is between single rooms and cubicled wards, because open barrack-type bedrooms would spell defeat of the very idea of convalescence. If the budget is limited, the last arrangement may have to be considered, but it is hardly recommended in the light of the objectives sought.

The small infirmary, intended for both guests and personnel, can be used in conjunction with the rest of the bedrooms when not otherwise occupied. In the event of an incidence of communicable disease, its location at the far end of a wing will offer facilities for isolation.

The suggested area of 80 square feet per bed in a private room is hardly more than would have to be allotted to it in congregate rooms. This area is based on space requirements of the furniture and equipment for each guest. Toilet and bathing facilities are decentralized to keep a reasonable distance between them and the extreme bed location. One of the shower compartments is so designed that a wheelchair can be wheeled into it by its occupant who would take care of himself without assistance. My associates and I designed this type of shower in the past, and it has worked out successfully.

ZONING FOR ACTIVITIES

All of the daytime facilities are on the ground floor, and are closely integrated with the outdoors. Whether the guest is in the dining room, library, social room, game room, occupational therapy shop, or auditorium, he will be at ground level. He will thus be free to go back and forth with ease.

The little canteen or bazaar has been included because of its beneficial influence. The ability to spend some money, however little this may be, reassures the guest that he is not expected to be penniless.

Among a hundred or so guests and 40 employes, there will always be talented people who might contribute amateur diversion or musical entertainment. The auditorium, intended for concerts and motion pictures and plays, will provide the necessary facilities for the expression of this talent. No doubt, visiting troupes and orchestras will help make the stay in the home more enjoyable. The stage or platform of this auditorium has been arranged so that it can be used in conjunction with the outdoors.

The far-reaching, curative effects of the various facilities for occupation, educational retraining and recreation should not be underestimated. In the presence of these functions, the guest's preoccupation with his condition tends to fade into the background, and his return to health is speeded. In contrast, boredom caused by lack of interest in his surroundings and time weighing heavily upon him could nullify the efforts toward his rehabilitation.

In order to instill in the guests a sense of physical security, it is proposed to construct the new building of noncombustible materials. The extreme end of each cottage is arranged for an emergency exit. Under these conditions there is no possibility of anyone being trapped in case of fire.

The main intercommunicating stairway is intended for use by guests in emergencies only, during unavoidable occasional failures of the elevators, and by those who are directed to climb a certain number of steps periodically as a therapeutic measure. However, this stairway is designed with low steps and its platforms are equipped with seats to facilitate its use when required.

The success or failure of this social enterprise depends a great deal upon its administration. By centralizing all office and medical suites within separate wings as shown, activities within this space will be undisturbed by extraneous traffic. All service areas, such as the main kitchen, storage facilities and laundry, are related to each other with consideration for the flow of personnel and material.

EXISTING FACILITIES

In a comprehensive analysis of a planning problem, consideration of existing facilities and of their disposition in the over-all program must take place to prevent duplication and waste. This project falls into this category. The house now sheltering the guests is of sound construction even though it is not fireproof. However, its use value is great. With very minor alterations it can be converted into a pleasant residence for the living-in employes. The grounds to the north and west of it can be reserved for the sole use of its occupants who also need diversion and separation from their daily chores. The existing driveway to it can also be used solely by these employes, thus segregating its traffic from the rest of the project.

Its dining room and kitchen can be retained without major changes, at least until experience with the operation of the new building dictates the consolidation of all food service for the sake of economy.

The use of the existing boiler room equipment should be discontinued. Instead, it is proposed to heat all buildings, existing and new, through the medium of a central heating plant, the location of which is suggested in the present service building. When a project grows to the size indicated here, it becomes advisable to include a laundry in its facilities. The employment of resident personnel for this laundry has several advantages: it helps in the preservation of linen, permits frequent linen changes which promote cleanliness and sanitation, and represents an economy in the over-all cost of operation. This laundry might be located in the existing service building, which would be altered in coordination with the existing home. There it can be serviced from the existing road at the extreme south end of the property and screened from the guests' view.

In connection with the site planning, the suggested rerouting of the main roadway to the south end is in accord with the premise that the guests' footpaths must not cross vehicular traffic. The garage entrance, too, can be altered to facilitate the maneuvering of the vehicles using it.

The presented solution springs from research into the many aspects of the intended functions. It is not, however, implied here that this is the only possible conception of the new home. Opinions and criticism are invited. From these, subsequent studies can be prepared and again submitted until the most desirable solution is achieved. This procedure, it is believed, is in the best interests of the project and the convalescent cardiacs for whom it is to be constructed.

Program for the Proposed Expansion of the McCosker-Hershfield Cardiac Home, Inc., Hillburn, N.Y.

ADMINISTRATIVE
- Entrance vestibule
- Reception and waiting room
- Telephone and toilet in conjunction with reception and waiting room
- Information desk and telephone switchboard room
- Mail center
- General office
- Duplicating and office supply room
- Director's office
- Assistant director's office
- Office for secretaries to director and assistant director
- Toilet for executives
- Office for social service
- Cleaner's closet on same floor with administrative offices
- Toilet for employes (may be on floor other than this suite)

SPECIAL SERVICES AND THERAPY
- Doctor's office
- Examination and treatment room
- Nurse's office
- X-ray room
- Film developing room
- Film viewing and storage room
- Room for electrocardiography and basal metabolism
- Dental treatment room
- Barber shop
- Occupational therapy room with storage closet
- Toilet room within this area
- Canteen
- Record storage (may be on floor other than this suite)

Note: suite to be accessible to cleaner's closet on same floor.

HOUSEKEEPING
- Supply storage room
- Cleaner's closets (one on each floor)
- Storage closet for floor polisher
- Linen closets (one on each bedroom floor)
- Attendants' toilet (one on each bedroom floor)
- Miscellaneous storage room

FOOD SERVICE
- Food delivery and trash room
- Storage for nonperishables
- Refrigerators for meat, vegetables, dairy foods, deep freeze and cook's refrigerator in main kitchen
- Main kitchen and pastry bakeshop
- Dishwashing and scullery
- Meat and vegetable preparation
- Garbage disposal and can washing and sterilization
- Toilet (within the food preparation area)
- Cleaner's closet (within food preparation area)
- Cafeteria service counters, with tray slide and back bar
- Dining room
- Ice-making machine

GUESTS' FACILITIES
- 100 bedrooms (including infirmary containing two isolation rooms with individual toilet rooms, and three sick rooms)
- Utility room for infirmary
- Nurses' station for infirmary
- Storage room for special equipment for infirmary
- Guests' toilet rooms (at the rate of one water closet to five guests)
- Guests' bathrooms (at the rate of one bath to 10 guests)
- Special shower room for wheelchair cases
- Linen closets (see program for housekeeping)
- Cleaner's closets (see program for housekeeping)
- Nourishment kitchen (one to each bedroom floor)
- Attendants' station (one to each bedroom floor)
- Drinking fountain (one to each bedroom floor)
- Wheelchair and stretcher closet (one to each bedroom floor)
- Attendant's toilet (see program for housekeeping)
- Sun deck (common for all guests)
- Dining room (see food service)
- Guests' toilets on ground floor
- Coat room on ground floor
- Living room, game room, music room, reading room
- Auditorium with projection space and dressing rooms
- Outdoor recreational facilities, shuffle board, horseshoe pitching, archery range, croquet

AUXILIARY FACILITIES
- Garage (existing facility to be altered to accommodate one bus, one station wagon, one truck and one power lawn mower)
- Power plant (existing facility to be abandoned; new boiler room in existing service building to provide heat from a central source, and high pressure steam for laundry, and possibly cooking)
- Maintenance shop (to be provided within existing service building)
- Sewage disposal plant
- Personnel quarters (existing home to be converted into these facilities)
- Laundry (to be provided within existing service building, which will connect via tunnel at cellar level with all buildings)

HUMIDIFICATION UNIT provides effective treatment—and it's portable

GENEVA KATZ, R.N.
Assistant Director, Boston Floating Hospital, Boston

WHEN the first case of tracheobronchitis arrived at your hospital this winter, you were faced, as we were, with the problem of effective treatment by cold water vapor. You may or may not have a vapor room. We improvised one last winter and with it successfully treated many cases diagnosed as tracheobronchitis, but we could not relieve the discomfort of the patient in a constantly moist bed, the inability of a nurse to work for more than an hour or two in such a moist atmosphere, and the difficult maintenance problem in trying to keep the vapor room from looking like the exhaust room for the autoclaves.

These are only a few of the reasons why we at Boston Floating Hospital felt it imperative to set up an individual humidified crib unit. It was necessary to find a way to care for several cases at one time, without the danger of cross-infection and, if possible, to care for them anywhere in the hospital.

The component parts of this humidification unit are: (1) canopy frame (A); (2) tent frame (E); (3) ice container (H); (4) humidifier (P); (5) humidifier stand (R); (6) canopy (L).

If you study the sketch and follow the directions as stated in the procedure, you will find that by the use of this apparatus one can obtain an isolated humidified unit and also satisfy the following conditions:

1. A relative humidity of 95 to 100 per cent.
2. An oxygen concentration of 44 to 50 per cent.
3. A temperature of 72° to 76° F.

PROCEDURE

1. Apply the frame (A) for the canopy support to the crib. Be sure that the lock bars (B), of the canopy frame resting on the head and foot of the crib, are placed between two vertical crib bars, so that they cannot slip horizontally. Also be sure to fasten hooks (C) across the hinged joint of the frame, so that it cannot be moved by the patient. If the extension arm (D) needs to be used for cribs of differing sizes, be sure it is locked in place.

2. Attach the tent frame (E) to the tent frame support (F) and chains (G) so that this frame is suspended from the humidification frame. Attach the open top canopy to its frame (E). Now lower the ice container (H) into place, being sure it is firmly hooked to the knobs on the inside of the metal frame. Draw the drainage tube (I) through the lower part of the canopy to its proper position over the drainage pail (J). Fill the ice container with ice. Attach the oxygen supply tube to the inlet tube (K) on the top of the ice container.

3. Place the transparent humidifying canopy (L) over the frame (A). Be sure that the inlet orifices (M) and (N) are on the left side of the head of the crib, because it will make for easier nursing care. The canopy will fit snugly if it has been applied correctly.

4. Insert the cold vapor supply rubber tube (O) leading from the center of the humidifier (P) through the lower of the two openings (M), being sure that it extends about 3 inches beyond the inside orifice, and extends *upward at all times*. The humidifier stand (R) has a support for this supply tube to help maintain this position.

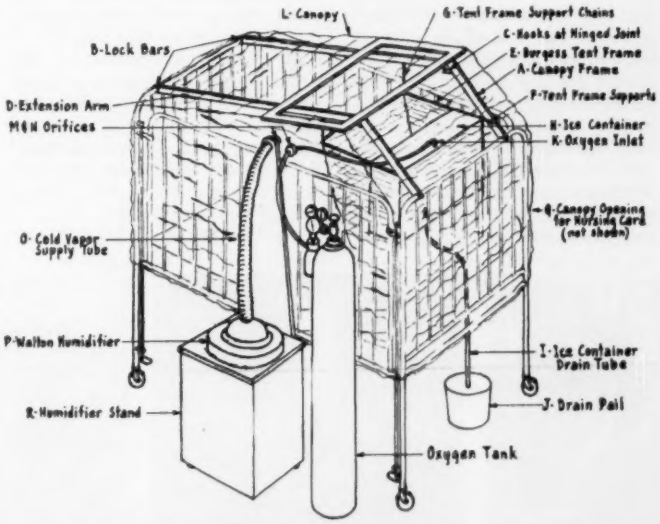
5. Bring the oxygen supply tube out through the other orifice and attach to a tank of oxygen. Tie the oxygen tube in place with the string attached to the orifice.

6. Fill the humidifier (P) with approximately 2 gallons of cold water. Turn on the switch.

7. Run the oxygen at 6 to 8 liters per minute. Be sure there is a small oxygen humidifier attached to the oxygen tank, so that the oxygen not only is being moistened by flowing through ice but also gains moisture by bubbling through water.

8. Tuck in the canopy underneath the mattress on three sides, always leaving the head end at the bottom loose to permit free exchange of CO_2 and an outlet for excess humidity.

We find that optimum conditions



Sketch of the humidification unit developed at Boston Floating Hospital.

are reached in half an hour, and it is better to have the tent ready before placing the patient in the unit, although it is not absolutely essential. We usually have sufficient warning to make this possible. The child's clothing does not get wet, and he feels very comfortable if he rests on a soft cotton blanket and has another one over him. His respirations are markedly relieved and, from experience, we find that the majority of patients slip into a quiet peaceful sleep after a very few minutes.

The nursing care is reduced to a minimum, as compared with the care necessary in a dripping steam room. If only a minor attention is necessary, the nurse may accomplish it through the opening provided (Q). If a major treatment is necessary, she and the physician may both work from inside the tent by merely lifting the side of the canopy, lowering the crib side, and letting the canopy fall down over their backs.

Observation of the patient is easy because of the transparent canopies, but if cloudiness does occur, a carefully deflected flashlight will aid vision.

We have used this unit in the treatment of several patients this last summer, and have invited our medical, surgical and anesthesiology departments to criticize it from all angles. They did just this, and were most helpful in clearing up many controversial points.

NURSING DEPARTMENT HELPFUL

Members of the nursing department were equally helpful in their constructive criticism, and were very patient while we made any changes. They kept careful statistical records of the conditions existing as we made progress, step by step.

The frame (A) and stand (R) were made by our maintenance department under our careful supervision. It is a simple piece of equipment to serve so great a purpose. We hope to simplify it even more after additional experience.

To help you obtain the excellent results that are possible from this individual humidified unit, the following precautions should be observed:

1. Be sure that the end of the cold vapor tube (O) inside the tent is higher than any other part of the tube. If the hole in the tube support is cut at an angle, this position will be assured.

2. Be sure that the opening of the cold vapor tube (O) inside the tent is not obstructed by the open top canopy or a slack piece of the humidification canopy.

3. Do not connect the second tube leading from the humidifier, because you soon get too much moisture by recirculating the same air in a closed circuit.

If your patient's condition necessitates only humidification therapy and not oxygen therapy, omit step 2 in the procedure. You will find that as soon as your patient recovers from the acute stage of difficult breathing, he has room to play in his isolated moist "house" and thoroughly enjoys himself, looking at the outside world.

We have found this unit extremely helpful in the treatment of many other diagnoses, such as post-vascular surgery, post-tracheotomy surgery performed for other than tracheobronchitis cases, and post-cervical gland cases with considerable throat edema.

If after reading this article you have any suggestions or constructive criticisms, they would be appreciated.

Conduct Hearings on Davenport Hospital Fire

DAVENPORT, IA.—As city and state fire authorities were conducting hearings here last month in an effort to determine the cause of the disastrous fire that destroyed an 80 year old psychiatric building at Mercy Hospital, costing the lives of 40 patients and one hospital attendant, a schizophrenic patient admitted setting fire to the curtains in her room in an effort to escape. While some doubt was expressed as to the credibility of her confession, the patient was held for investigation.

Known as the St. Elizabeth Ward, the building destroyed by fire was a brick structure with wood interior; it was three stories high and had 65 beds. Twenty-four patients in the building were safely evacuated after the fire started, it was reported. Many of those who died were prevented from escaping by heavy bars on all the windows, which also prevented firemen from entering the building promptly to effect rescues.

The building was equipped with two outside fire escapes and two other exits, it was reported, but these were all kept under lock because of the nature of the patients.

It was tentatively established that the fire started in a room on the second floor of the building, then spread to a corridor and up a dumbwaiter shaft to the top of the building. The second floor had recently been remodeled and modernized at a cost of $25,000. Total property loss was esti-

(*Continued on Page* 152.)

Acme Photographs

A community hospital learns

A Lesson in Public Relations

...there's a moral in it somewhere

MALCOLM SMITH
Administrative Resident, Montefiore Hospital, New York City

CHRONIC Cripple Learns to Walk!" Like flames crackling through a forest of virgin spruce the knowledge spread to the farthest reaches of America. The people read the good news in a popular magazine. They read it riding out from town on the tailboard of the Ford or leaning against the bulwarks in the last gleam of a San Francisco sunset. Sooner or later they read the copy in the doctor's reception room, or they read it curled up on a bench in a Kansas City bus depot. Cripples had been incapacitated for thousands of years, perhaps longer. Was this the answer they had been waiting and praying for?

THIS WAS THE STORY

"Four years ago, crippled by a spinal ailment, 55 year old John Mahoney entered the Community Hospital. His recovery began with massage and hydrotherapy that restored tone to the muscles and nerves of his legs. Then, through months of painstaking re-education in balance and coordination, he progressed from the hospital's 'giant baby-walker' to crutches and later to canes. Today, fully recovered, he is walking normally again. Cases like this are pioneer steps in U.S. medicine's increasing effort to turn chronic patients into convalescents."

This, with pictorial illustrations, was, in essence, the story that was being carried to the citizens of our country in an attempt to kindle hope in the breasts of the handicapped and to demonstrate the growth of an idea in a hospital. Few of the publicists concerned realized how numerous a reading public it would reach. An enterprising and popular weekly magazine heard the story and induced Community Hospital to release it. Hours of careful consideration by representatives of the magazine and hospital were devoted to this release.

Time and time again questions were raised. Would this release harm in the slightest the professional dignity of an outstanding hospital, a dignity that had been growing since the 1880's and which had, even now, not yet reached complete fulfillment? Would the story be in the least warped and distorted as such stories often are, so that the reader might gain a totally unintended impression? Would any claims be made that were not of the most truthful and sincere nature? Would there be any legal restrictions on the disclosing of privileged information in this way? Would false hopes be raised?

In addition to answering questions like these, there was the problematic effect. How would the reading public respond to such an article? Would there suddenly be released an avalanche with which this and other hospitals could not cope because of already greatly burdened facilities? What would be the attitude of other hospitals and the medical profession to this news release? Let us consider some of these questions.

First, the professional dignity of the institution was to be protected by writing the name of the institution in small letters and using it only when absolutely necessary. Also, individual names of trustees, doctors, and directors would not appear in the article. The only exception was the name of the patient. Any statement or photograph hinting at exaggerated claims or sensationalism was carefully removed.

Second, photographs, captions and script were scanned for material that even though true, might be distorted in the reader's mind and bring the wrath of the medical profession down upon this conservative institution.

Third, as to the factual quality of the script and captions, this in itself did not require as much detailed scrutiny, as it was relatively simple to remove any statement that did not measure up to the standard of strict truthfulness and sincerity.

MUST OBTAIN RELEASE

Fourth, as to the matter of legal restrictions, Mills states in his book, "Hospital Public Relations": "The information that the hospital has concerning its patients is confidential and privileged. The hospital has a duty to withhold such information." Therefore, it was necessary to obtain from the patient, after making perfectly clear to him the significance of this release, permission to use the story of the treatment he received which was, in effect, his privileged information.

The probable reaction of the reading public was difficult to estimate. It was expected that this article would arouse interest and sympathy in the lay public for the plight of the long-term patient (a term that is almost synonymous with poverty) and create, at the same time, a desire to aid in financing the care of such patients. A slightly increased demand from the immediate surrounding community for the har-

assed facilities of the hospital was anticipated. This estimate proved to be only partially correct.

Among additional benefits, it was expected that other hospitals, particularly those caring for the long-term patient, would benefit from this stimulant to philanthropic impulses. Great care was taken to avoid an unfriendly attitude toward other institutions by implication. Only after all this exhaustive groundwork had been completed was the dramatic story of this patient released to the reading public.

The extent of the response was not anticipated. From every section of the country, from the wealthy, from the destitute, from farm areas, from mining regions, and from city dwellers the letters began to pour into the hospital pleading for relief from conditions which were seldom exactly similar to the case in point. Whenever a crippled patient read, or had read to him, the story of the cure of John, hope was kindled. If the hospital could do so well by him, how about me? Such people grasp at straws. Most of the letters were written from the heart in the halting scrawl of the aged. All of them carried stories of human suffering, patience and endurance enough to arouse the compassion of the most hardened.

At first, the hospital answered each letter on a personal basis but, as the volume of mail began to increase, the need for a form letter became evident. This time a form letter that would channel the pleas for aid away from this hospital, which, obviously, could not take on all applicants, and into the communal hospitals nearest the source of the individual requests, was prepared. Here it is.

"We are addressing this letter to all those readers of *Popular Magazine* who took notice of our work and made inquiries about the possibilities of receiving the same kind of treatment that was given to the patient whose case was described in the April 22d issue of the magazine.

"Community Hospital is not in possession of any form of treatment which is unknown to the medical profession at large. There is no step in the treatment of the patient around whom the article was written which cannot be repeated elsewhere for the same causes, under the same conditions, by a competent medical staff and a patient nursing group, in cooperation with efficient technicians in physical therapy. There is, therefore, no reason why any sufferer from the same disease should come to New York for this treatment. The article in *Popular Magazine* simply illustrates what competent medical care, good nursing and efficient technical physical therapy can accomplish for a patient suffering from a curable form of paralysis. There is nothing secret about our methods and these methods are, indeed, practiced every day throughout the country, though not often with the same successful results.

"We strongly advise that you apply to the nearest high-grade hospital to your home for advice concerning your condition."

Eventually the overwhelming influx of mail subsided, though it tapered off over a period of years, as long in fact as people read old numbers of magazines. The routine of applications returned to normal. No one could deny that Community Hospital had meant well. No one could deny that a mistake had been made somewhere though no one could clearly diagnose it.

This experience in the relationship of a hospital to the people that surround it has been presented in the hope that the lessons we learned will be of assistance to other hospitals in their planning, organization and release of local and national publicity. Here is a problem in public relations which is waiting for a solution. How shall we inform the public of newly developed remedies without running the risk of such a reaction as this—a reaction which involves the practitioner eventually almost as much as it does the hospital?

Practical Summary of Malpractice

A CONCISE restatement of malpractice—one which is easily comprehended by the nonlegal mind—is presented in the Nov. 12, 1949, issue of the *Journal of the American Medical Association* as "The Problem of Malpractice" by Louis J. Regan, M.D., L.L.B.

Malpractice is essentially professional negligence, the author maintains. The legal criteria for such a judgment are: (1) whether or not the physician has used reasonable care, attention and diligence in the performance of his professional services; (2) if he has acted according to his best judgment in treating his patients, and (3) if he possesses and has exercised the degree of skill and learning ordinarily possessed and exercised by his colleagues in the same or similar locality. This last point is important because a specialist, or one who holds himself out as a specialist, must have and exercise the degree of care and skill possessed by specialists in that field of practice and in that locality.

Because the judgment in such cases can usually be given only by the medical profession, and the burden of proof is on the plaintiff, ordinarily a malpractice action will fail unless some physician testifies for the plaintiff, condemning the defendant physician's conduct of the case.

There are, however, important exceptions to this necessity for expert testimony. The following exceptions are most dangerous to the physician:

1. Actions based on allegation of operation without consent.
2. Invasion of the right to privacy, *e.g.* unauthorized release of privileged communication.
3. Breach of warranty to cure or obtain a definite result.
4. In matters which are within the common knowledge of laymen.
5. When the practitioner admits negligence by his own statement.
6. When the doctrine of *res ipsa loquitur* (the thing speaks for itself) is held applicable.

This last doctrine, the author contends, is of increasing importance in the law of malpractice as its application creates an inference of negligence on the part of the defendant physician. It has been applied in slipping instruments, burns from diagnostic x-ray and physical therapy procedures, and infections resulting from unsterile instruments. The real danger in the gradual extension of this doctrine is that eventually any bad result may bring a malpractice action.

The author includes recent court decisions in malpractice cases and closes with 23 recommendations on how to avoid being sued. He urges that every physician be fully covered with malpractice insurance.—J. D. THOMPSON, *Montefiore Hospital, New York City.*

People in Pictures

At the convention of the American Pharmaceutical Manufacturers' Association, Dr. Theodore G. Klumpp (right) chats with visitors. These are (l. to r.): R. Adm. Carlton L. Andrus, U.S.N.; Dr. Rollo E. Dyer, National Institutes of Health; Dr. Joseph C. Hinsey, dean of the Cornell Medical College, and Dr. Elmer L. Henderson, A.M.A. president-elect.

Gov. Thomas E. Dewey cuts a birthday cake at the sixtieth anniversary of Beth Israel Hospital of New York City. Watching the ceremony were, left to right, Ralph E. Samuel, president of the Federation of Jewish Philanthropies of New York; Charles H. Silver, president of Beth Israel Hospital, and Mayor William O'Dwyer.

Above: At the dedication of a floor for the care of 150 tuberculous patients of Manhattan General Hospital, New York City, Dr. Marcus Kogel, commissioner of hospitals, Mayor O'Dwyer and Dr. Alfred A. Richman, executive director, talk with Mrs. Emma Edler, one of the patients. This is the first time a private hospital has accepted city patients. Left: Easton Hospital, Easton, Pa., was presented with this bassinet for premature infants by its women's board. The gift was made possible by contributions to the Memorial Fund of the women's board, the purpose of which is to make available a means of honoring the memory of a friend or relative with a living memorial. In the picture are, left to right: Ruth Bickel, R.N., assistant director of nursing service; Mrs. George Shillinger, president of the women's board; Helen Morris, R.N., director of nursing service, and Arthur H. Brittingham, administrator of Easton.

The Budget Is the Yardstick

by which management can measure the accomplishments of each department and the institution as a whole

LAWRENCE BRETT
Administrator, Lexington Memorial Hospital, Lexington, N.C.

THE mention of a budget to most of us brings many and varied reactions, depending upon our prior association with the word. However, unpleasant or pleasant, the idea behind "budget" is that we must have a standard to measure by, to live up to, or to guide our operation and performance. These many meanings are usually measured in dollars and cents, but money need not be the end unit of measurement.

Any institution consciously or unconsciously measures its performance in some way; it may be against a formal budget or it may be against the experience of past years or past months but it is measured against something. I have found that a formally prepared budget gives greater control, better realization of the problems facing the institution, and a planned method of accomplishing its purposes. Also, after putting the problems down in an orderly manner (as represented by the departmental expenses) I have a definite method of judging how well the institution as a whole is accomplishing the job and if there was a proper emphasis on each department.

MUST AGREE ON SALARIES

Because the board of trustees must of necessity leave the actual performance of administrative duties to its designated officer, it behooves the board and administrator to be in complete agreement as to the amount of money to be spent on salaries and supplies inasmuch as these are the building blocks of service to the patient. From the administrator's standpoint, it is most important that his trustees understand in detail the budget figure for salaries as this puts their stamp of approval on the number of employes and sets the level of service possible. When and if complaints are received about the number of employes, it is then the board's responsibility to change the standard, not the administrator's to explain "why." A budget shows the best judgment of management before action is taken.

The realization of difficulties and their presentation is not intended to discourage but to prod the mind into finding logical and simple answers. With this premise, I think the first problem to confront most small hospitals in setting up a budget, or in any other undertaking that requires money, is establishing the basic average income for the institution for a year or a month, or any set time. The small hospital's census fluctuation is such that a very small number of patients either up or down makes a large rise or fall percentagewise. This cannot help but upset the income derived from patient care, and hence limit the amount of "certain" income for use in providing facilities.

A related problem stemming from the same source is that of arriving at an average expense of serving each patient from the standpoint of supplies. By supplies I mean all items necessary for patient care. The apportionment of expenses presents still a third major problem to the small hospital where many employes must do more than one clear-cut and definite job. This salary expense must be apportioned to the proper activity in a way that is simple and easily checked.

To those who successfully solve these problems in some practical way accrue the advantages of being able to equalize the personnel needed to assure good standards in professional care, proper upkeep and maintenance, and avoidance of the disadvantages from over or under inventory of supplies needed in the operation of the hospital. Stemming from the successful use of the budget principle are long-range policies which allow the institution to accomplish the much desired ends of building up a reserve for equipment or replacement of plant facilities by a view of over-all expenses and income. With the over-all view of both expenses and income, necessary adjustments in charges to bring in sufficient income are then possible.

The Mechanics of Small Hospital Budget: The evaluation of any type of business is made on the basis of the units which it produces; the units of service which a hospital produces are evaluated in terms of patient days of care. In hospitals that have an active outpatient service, the number of outpatient visits can be used in that department, but I am only concerned in establishing an inpatient budget, so we will use only days of care, both adult and new-born. A review of the last year's work to obtain these figures, broken down by months, enables the monthly average to be taken and each month compared to the average to obtain occupancy highs and lows. A survey over several years is necessary to show the percentage of growth or loss and to change this trend into a percentage figure which can be used in computing future expected increases or decreases in income. After obtaining the total number of patient days for the last year, the average daily occupancy can be computed according to the American Hospital Association accounting manual for both adult and new-born patient days.

TWO YEARS' EXPERIENCE DESIRABLE

As the expected income is the least fixed and hardest factor to obtain in making a budget, I would suggest that past experience over at least two years be used in getting the total income derived from inpatient service. If we deal with the income figure as a total instead of trying to apportion expected income to departments at this point, the task will be simplified. When the income accounts are reviewed and total inpatient income is computed, the percentage of growth or decline can then be applied to the total figure, giving

the computed expected income for the ensuing year.

Inasmuch as it is easier to handle income on a per patient day basis, the division of expected income by the last year's experience of total patient days will give the income per patient day to be expected toward which expenses may be computed and compared. An analysis of income produced by each revenue-producing department for the previous year is most desirable, but in the initial computation it may be confusing and will not help the administrator to arrive at the per patient day figure for expected income. In our situation, we reduced income to adult patient days, raised our rates in some instances, and cut expenses to fit our income.

Expense Accounts: Any practical budget must be computed from experience and the only way to find this experience is to review the bookkeeping records for past years; hence, any small hospital must have a reasonably efficient accounting system on which to base budget experience. The accounting system as set forth in the American Hospital Association accounting manual gives all the necessary components on which to base a budget. The breakdown of expenses into the three components: "Salaries," "Supplies" and "Miscellaneous" is a sufficient division in most department classifications to be both practical and simple. Here, again, as in the income accounts, a better over-all picture may be obtained if the classification of accounts is just listed and the total expenditures for the year are set down.

For the first budget, it would be wise to follow as closely as possible, compatible with good accounting practices, the past classification of accounts in order to have sufficient background experience to make a yearly average. However, if greater clarity of purpose is gained by a new accounting setup, research and estimation will give a beginning figure. In our situation here at the Lexington Memorial Hospital, I have found that a budget made up for six months at a time gives about as good a control as can be expected of both income and expense; this allows for a closer evaluation of the economic conditions in the community and the evaluation of the expected income and service needed.

Salaries constitute more than half of the total expenditure for operating expenses. In order to arrive at a figure for salaries, it is necessary to make a breakdown by departments, with the number of employes and their classification in the department. Here should be listed (1) the standard wage rate for each job plus the expected raises, if any; (2) an estimate for vacation if the person must be replaced for vacation and the work cannot be done by someone else in the department, and (3) an estimate for sick leave if it is given.

This work of establishing the number of employes is best done with each department head individually, and for the period of the budget will act as a guide and yardstick for the performance of that department. If yearly totals for each job classification can be made, a clearer over-all picture of the salaries concerned can be obtained. If the total figure for salaries is arrived at and divided by the total expected patient days, the cost of salaries per patient day can be found.

In reviewing the accounts to ascertain the amount per patient day that is used in supplies and miscellaneous, it is easier to follow either the previous year's classifications or the A.H.A. accounting manual. The total of supplies and miscellaneous for the entire year can then be converted into a cost per patient day for each department. From the total of other expenses that cannot be apportioned to any one department, such as depreciation, adequate provision must be made to load the per patient day rate to give a sufficient margin of funds to cover this type of thing. Thus the reduction of total cost to per patient cost for a comparison with expected income is not only desirable but necessary.

As is often the case, the expected income is not sufficient to meet the expected expense, yet the cut in each department's expenditures must be made on a percentage basis of what that particular department used of the total salaries, supplies and miscellaneous expenses the previous year. This type of apportionment is much easier to do in the division of supplies and miscellaneous expenses than it is in salaries.

The percentage basis can have numerous applications in small hospital budgeting as it gives the department in question an equitable share of the income on either a decrease or increase in census and, hence, income. For example, if the dietary department was to receive 34 per cent of the amount apportioned to supplies, say $4.05 per patient day, which would be $1.38, and it was later found by experience that owing to a decrease in the cost of supplies, the total supply

BUDGET—Dec. 31, 1948 to July 1, 1949

Computed on 1368 adult days per month. Supplies $4.05 per patient day.
Miscellaneous $0.95 per patient day. Expected income $12.10 per adult day.
Expected cost $11.24 per adult day.

DEPARTMENT	EXPECTED EXPENSES	ACTUAL EXPENSES BY MONTHS Jan.	Feb.	March	April	May	June
	Actual Census						
Administrative							
Salaries	$1153.00						
Supplies	376.50						
Miscellaneous	61.86						
Maintenance and Repair							
Salaries	325.00						
Coal	503.42						
Maintenance and Repair Miscellaneous	97.12						
Housekeeping							
Salaries	568.00						
Linen	756.04						
Supplies	321.48						
Miscellaneous							
Dietary							
Salaries	861.00						
Food	1887.84						
Dietary—Other Miscellaneous	151.84						
Laboratory							
Salaries	350.00						
Supplies	95.76						
Miscellaneous	27.36						
Pathology							
X-Ray							
Salaries	110.50						
Supplies and Miscellaneous	110.80						
Repair							
Dr. Andrew	350.00						
Medical and Surgical							
Operating Room Salaries	802.50						
Anesthetist	300.00						
Medical Records	177.50						
Medical and Surgical Supplies	1026.10						
Medical and Surgical Miscellaneous	205.20						
Nursing							
Nurses' Salaries	2186.80						
Orderly	547.00						
Aides	1304.00						
Pharmacy Supplies	1140.91						
Pharmacy Miscellaneous							
Nurses' Home							

PERSONNEL BUDGET BY DEPARTMENT

Dietary Department—Dec. 31, 1948 to July 1, 1949

Job Classification	Salary Range	Number Needed	Salary	Raises Sick Leave	Yearly Totals
Dietitian	$135.00-165.00	1	$160.00	$ 58.00	$1978.00
Head Cook	130.00-150.00	1	135.00	55.00	1675.00
Assistant Cook	85.00-100.00	1	90.00	40.00	1080.00
Salad Girl	65.00- 80.00	1	70.00	31.00	871.00
Cleaning Girl	65.00- 80.00	1	75.00	26.50	926.50
Diet Girl	65.00- 80.00	1	65.00	30.50	810.50
Relief Girl	65.00- 80.00	1	65.00	30.50	810.50
Dishwasher	70.00- 90.00	1	80.00	36.60	996.60
			$750.00	$308.10	$9148.10
VACATION: ½ of Month's Pay					375.00
YEAR'S SALARY COST ESTIMATE					$9523.10
MONTHLY ESTIMATE					$ 793.59

budget could be cut to $3.75, the dietary department would get $1.28. Again, if it was discovered that costs of certain food items had advanced so as to make 34 per cent inadequate for food costs, yet total income had not risen and the total expense was inflexible, a curtailment would have to be made in supplies to other departments or the quality and amount of food used would have to be cut sharply to keep within the budget. However, if income increased, the amount for supplies could be increased and the dietary department would get its proportionate share. This type of control affords a good check on the comparative efficiency of each department.

The yearly totals for each category of expenses under each department are divided by 12 and apportioned, so much each month. This method of apportionment is the simplest, but the apportionment can be made on a sliding scale according to expected income per month. This is usually a difficult procedure for a small institution as it requires a fairly large and experienced accounting staff first to get up the original figures and, second, to keep the budget posted up to date. The average basis is the simplest, and where there are seasonal fluctuations in patient census, the budget may be made up for shorter periods. Because most small institutions operate with as few people as possible, an average of the amount of personnel and supplies needed would help the institution to decide what its average service to the patient was to be as shown by its average ability to pay personnel.

ANALYSIS IS ADVANTAGEOUS

A close analysis of the operations of the institution must be made to make up the budget, and that inspection will possibly bring to light certain advantageous changes. The analysis will also provide a routine check on the classification of expenses and a monthly review of each expense account. Comparison of income accounts with budget classification accounts will tend to reveal reasons for losses, if any. Since the basis of the accrual system of accounting is the amount of charges, it is often found that actual charges are not enough to meet the monthly expenses, or that credit losses are so great that even though charges are more than enough to meet expenses, cash income is not sufficient to carry the expense load. Hospitals cannot make money in a positive way, but by economies of operation they can give more and more services for the same fees. In this respect, the budget throws the light of understanding on the dark and often unexplored corners of some departmental expenses.

Refrigeration Anesthesia

THE alert hospital executive will be aware of the administrative problems inherent in the article "Amputations Under Refrigeration Anaesthesia" by James L. Wilson, M.D., published in the September issue of the *Harlem Hospital Bulletin*, New York City.

Use of refrigeration in 44 amputations, the author states, is of interest because of: (1) its application as an anesthetic agent; (2) its use preoperatively as a therapeutic agent in wet gangrene; (3) the absence of interference with preliminary healing when ice and tourniquet are used for the period described, and (4) the reduction of mortality.

Most of the patients were toxic and debilitated and were in the older age group, that is, between 44 and 91 years of age, and they were not suitable for either spinal or general anesthesia. Because of previous high mortality in this type of patient, the doctors became interested in this method of anesthesia in an effort to reduce mortality.

The method of refrigeration anesthesia used was a modification of the Allen technic. The limb was packed in a layer of finely cracked ice about 8 cm. thick, and wrapped in a rubber sheet. The packing of ice included the toes and extended about 10 cm. above the proposed site of amputation. The head of the bed was slightly elevated to permit the melted ice to drain from the rubber sheeting into a pail on the floor. The ice packing was maintained without cessation until the time of operation. For thigh amputations, refrigeration was continued for seven hours, and for leg amputations below the knee, five hours. It is necessary to emphasize that the ice must be replenished frequently. There was no evidence of devitalization of tissue or an increased tendency to infection or arterial or venous thrombosis when ice was used for these periods of time.

The author states that the temperature of the deeper tissues of the limb must be from 10 C. to 6 C. before successful anesthesia is obtained. He observed that at 11 C., the skin, the subcutaneous tissues, and the muscles are anesthetized, but not so the nerves, the intermuscular sheaths, or the periosteum. In six cases of this series, amputation had to be completed under gas-oxygen anesthesia. The temperature of the deeper tissues in these six cases varied from 12 C. to 15 C., and the failure of satisfactory anesthesia was traced to faulty technic owing to inadequate packing or replenishing of ice around the extremity. The anesthesia in the 38 successfully anesthetized cases lasted from forty to fifty minutes after the release of the tourniquet. The author believes that there is every reason to expect that greater refinements in the application of refrigeration will develop.—MALCOLM SMITH, *New York City.*

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CIRCUMCISION

Rites and Rights

IN THE days of Moses and Joshua, according to the Old Testament, ritual circumcision was performed with sharp stones. The present generation has witnessed many changes in the procedure. Wide latitude is given to the mohel by the Jewish religion in the choice of instruments and technics. Scissors may be used, a blade, or any sharp tool.

One of the innovations has been the use of special-pointed little scissors to make the dorsal slit in the ballantic surface, which usually adheres to the prepuce after the foreskin is cut off. For centuries this part of the operation had been performed by the skillful manipulation of a sharp thumbnail. At present the o-clamp is employed as a guide and safeguard in the use of the circumcision knife and to prevent undue bleeding.[1]

It is a fundamental Jewish law that the father of the male child chooses the mohel to perform the ritual circumcision on the eighth day of the newborn. Although it is the practice for the father to select the mohel, the hospital in which the operation is to be performed has the right to reject him for any sufficient reason.

Exclusion of Mohel Upheld

A rabbi of the Hebrew faith qualified as a mohel, whose function it was to perform the ritual circumcision upon male children in accordance with Hebrew religious requirements, applied for a court order to permit him and other members of his association to perform circumcisions at the hospital, when requested by the parents of male children.

The hospital refused to permit this mohel or other members of his organization to do circumcisions at the hospital, although others were allowed to perform the same ritual. Such exclusion, argued the mohel, deprived him and the parents of their constitutional rights, consisting of the "right to freedom of worship; the right to pursue freely their religious beliefs; the right of Jewish parents to designate a mohel of their own choosing; the right to perform religious acts and rites without interference" . . . that there was discrimination on account of "race, creed or color," in violation of the civil rights law of the state.

The court dismissed the complaint and denied the application for the order. Both the federal and state constitutions, said the court, proscribe any governmental actions which relate to religion, but do not bar "private conduct, however discriminatory or wrongful." Although in certain respects the hospital performs governmental functions, particularly in respect of free patients, it is a private corporation in all other respects. In no aspect of the case is the hospital the agency of the state in respect of religious matters. The provisions of the constitution have no application to "private conduct" of the character here involved by a private corporation.

There was no discrimination on account of race, creed or color, because other mohels were admitted to the hospital. No inherent right exists to use hospital property for private purposes, whether for profit or otherwise.[2]

The mohel is in no different position from physicians in the community: neither has an inherent right to the privileges of the hospital, as demonstrated in another case. The father of a child patient sought a court order directing the administrator of a charitable hospital to permit the patient's private doctor to treat the child. Permission to enter the hospital had been denied to this physician by a resolution of the trustees.

The order was refused, the court holding that since the hospital was maintained by a private corporation through its endowment fund and voluntary gifts it could exclude undesirable practitioners. The fact that it did charitable work for the public benefit or that it received money from the city or county for the care of sick indigent persons did not make the hospital a public corporation.[3]

Must Obey Hospital Rules

Regulations of the hospital may prescribe that the mohel comply with its aseptic technics. Those doing circumcisions may be required to scrub, wear gowns and gloves, and to observe the same technic as a surgeon performing a minor operation. The ceremony should be performed in a room assigned by the administrator of the hospital, and the patient's physician or a resident should be present during the circumcision.[4]

It has been found desirable for the hospital not to suggest a particular mohel, for the administrator may be accused of partiality by the other local mohels; the mohel may be charged with having a monopoly. Moreover, the hospital is absolved of the duty of "due care in selection" when the father chooses the mohel and signs a statement that he has satisfied himself of the mohel's qualifications and assumes responsibility for any consequences and releases the hospital, its staff and other personnel.

Some hospitals require the mohel or rabbi to sign a statement certifying to the identity of the child to be circumcised, that he has examined the baby's name necklace or other identifying mark, consulted with the parents, and is satisfied of the baby's identity, and that dressings are to be done within certain designated hours.[5]

[1]Felshin, Rabbi Max: Ritual Circumcision Adopts Modern Methods, New York Physician, July 1946, p. 48.

[2]Zlotowitz *v.* Jewish Hospital, 84 N.Y.S. 2d 61, 193 Misc. 124.

[3]Bronner *v.* Elizabeth A. Horton Memorial Hospital, N.Y. Law Journal, October 3, 1945, p. 753.

[4]MacEachern, Malcolm T.: Hospital Organization & Management. Chicago: Physicians Record Company, 1947, p. 992.

[5]Felshin, Rabbi Max: Religious Rights of Obstetric Patients, New York Physician, May 1942, p. 42.

The hospital should provide conditions which do not subject the infant to the possibility of infection from outsiders; a special room for ritual circumcision is advised. Spectators are to be kept on the outside looking through a closed glass door. After a circumcision the bed is tagged to indicate the nature of the operation, and the infant is given special attention. Vaseline dressings are applied after each voiding until healing has occurred. When the circumcision is performed by a doctor, the operation is carried out in the delivery room and the usual aseptic precautions are observed.[6] The record should show who performed the circumcision, dressing applied, and subsequent observations.

[6]Busch, M. L.: Impetigo Loses Another Round, MOD. HOSP. **54**:73 (April) 1940.

Ordinary Skill Required

The mohel, like the surgeon, is required to use ordinary skill in the performance of the circumcision. In nonritual circumcisions, the usual authorization as in the case of any other surgical procedure should be obtained from the responsible parent, irrespective of whether the case is a private or ward patient. The physician must employ the usual precautions for the protection of the child, and his best professional judgment and skill.

A physician was charged with performing a circumcision improperly. The infant son was taken by his father to the physician who with his own wife's aid performed the operation, using a circumcision clamp. The father and grandfather were called in immediately after the operation and approved the result. Two weeks after the operation another surgeon had to perform an additional circumcision. He testified a scar around and back from the end of the child's penis made it necessary to cut through the scar tissue and to dilate the skin of the organ. There was no medical proof that the first doctor had not used ordinary skill and had not used ordinary methods for the operation. The complaint was therefore dismissed.[7]

[7]Johnson *v.* Colp, 300 N.W. 791 (Minn.)

THIS APPOINTMENT SYSTEM IS WORTH THE EFFORT

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APPOINTMENT systems! Are they worth the time and effort? At Vanderbilt Clinic we feel that our system is, for even though it has not reached perfection, it has raised the quality of medical care and services to patients—a goal we are all striving for if we are to continue in existence.

The pioneer work done by the members of the outpatient department committee of the American Hospital Association has already set down for us the numerous advantages derived from an appointment system:

1. Certain limitations are placed on the number of individuals accepted for care at any one time, thereby minimizing to a certain extent overcrowding and confusion.

2. The patient obtains prompt service from the same physician. There is opportunity for follow-up and the clinic physician is allowed to assume the rôle of the family physician.

3. Each physician is able to realize the extent of his work and as a result he is able to conserve his time.

4. The result of allowing a definite period of time for new and old patients is more thorough examination and consideration of the patient's condition.

Experience reveals that an appointment system does act as a limitation on the number of individuals, but to what extent it serves in the other three instances is a matter for considerable debate.

Several significant problems are encountered in attempting to administer an appointment system.

In Regard to the Patients

1. In a large general clinic making approximately 100 appointments a day with an adequate medical staff in attendance, one finds 20 per cent of the patients will break their appointments without notification; another 25 per cent of the patients will be late. The possibility of resorting to disciplinary measures is complicated by whether the seriousness of the patient's physical condition precludes refusal of admittance. And, in addition to these routine problems there will be certain patients who are eligible to be seen but do not have a specific appointment.

In Regard to the Physicians

1. In any clinic to which 10 physicians are assigned, an average of two will be absent and the majority will be late.

2. In the instance of the absent physician his colleague is asked to see his patients and one of the main purposes of the appointment system is defeated.

3. In those cases where the physician is on time, but his patients are late, it is interpreted as a waste of his time and quite often this is used as an excuse. It also might be pointed out that the reverse is true if the patients arrive at the proper time and the physician is late; they reason in a similar manner, and once again the time table is upset.

4. Another feature interfering with the appointment system is the problem of teaching. Theoretically this is simple to control, but to date no satisfactory method is known to control this problem.

It is generally agreed that the most acceptable form of medical service for the ambulatory patient is that given by the individual physician in his private office. In this service the average patient occasionally experiences a waiting period and there would seem to be no logical reason why individuals who are eligible for clinic care should be trained to expect something superior to the private office.

In our particular situation we have experienced difficulty in our appointment system. Inasmuch as we have a large number of patients per day and since there are many variable factors,

we unfortunately have not been able to administer an appointment system which obviates waiting and other unsatisfactory features.

First of all, patients accepted for care at Vanderbilt Clinic receive an appointment card on which the clinic secretary records the date of the next appointment as ordered by the attending physician. She also records the date of the return visit on a file card under the date of the appointment so that she can requisition the patient's chart from the record room for the appropriate time. In the event that the patient does not have an appointment card a single appointment slip is provided for the next clinic visit.

Overcrowding is the most serious problem in the management of clinics.

NOT AN EXACT APPOINTMENT

The foregoing routine provides the simple mechanics of having the patient arrive at the proper clinic on the right date. This is in no way an exact appointment, such as "Mrs. Jones to see Dr. Smith at 2:45 p.m." It merely permits Mrs. Jones, if she arrives, to see Dr. Smith, if he arrives, with the rest of the patients who are attending the clinic under the same circumstances. Furthermore, this system does not prevent either overcrowding of clinics or the incomplete use of available clinic appointments.

About two years ago, we inaugurated a new system, which is still in the experimental stage, approximating the appointment system of the private physician's office as nearly as possible. Bearing in mind the many variables, we were forced to abandon any hope of obtaining an appointment system which permitted an exact time of appointment. This forced us to accept what we call a stagger system whereby patients are given appointments at 15 minute intervals so that by the law of averages all patients do not descend upon the clinic at one time. In general, the first hour is reserved for new patients and the remaining time for revisits. This has been of limited help as many patients still prefer to come early, hoping to be seen before their time of appointment.

To meet the problem of overcrowding, we have established a quota for new patients in our large general clinics. This quota is dependent upon the available staff, space and time needed for examination in the various specialties. All appointments for these larger clinics are obtained at the main appointment desk where the central appointment books are kept. This desk can be reached by telephone from any of the clinics and is easily accessible to the admitting interviewers who see the new applicants and arrange their appointments and assign a financial rating. In the case of a medical necessity where the patient is not an acute emergency but should have an immediate appointment, an extra appointment is permitted. By this method then we control the number of patients who are going to that particular clinic for the first time. They may or may not, of course, be new to the institution.

To control overcrowding among the return visits, the clinical secretary, by means of the card file previously mentioned, can estimate her return visit load; should she see a particularly heavy day in the future, she may suggest to the physicians a return appointment at a more suitable time either before or after the heavy day.

In our smaller, highly specialized clinics, we have no quotas and they can absorb the few patients eligible for that type of service.

In any discussion of appointment systems, I believe it is wise to bear in mind that no matter what system one has instituted to fit individual problems, there should be functioning simultaneously a method of checking the mechanics of organization. If the procedure is not periodically checked the system will likely fall into disrepute with all concerned and everyone will fall back into a "leave well enough alone" attitude with all its demoralizing effects. It is important to observe all three of the individuals responsible for the performance of the appointment system:

1. *The Physician.* Everyone understands that a physician's appointment in an outpatient department carries with it certain responsibilities. However, it is occasionally a wise move on the part of an administrator if he institutes a system of checking the attendance of the physician by having the clinic secretary record the hour of arrival and departure.

2. *The Patient.* An occasional time study of the arrival of patients and the time they are seen by the attending physician and any other pertinent facts deemed necessary can reveal a great deal to the betterment of the system. The possibility of the use of your volunteer group as the surveying unit in the time study should be kept in mind.

3. *The Clinic Secretary.* Constant surveillance by supervisory personnel is the obvious method of seeing that the clerical personnel performs its duties.

No Rate Reduction Is in Sight

a survey of 55 small hospitals shows

RATES for accommodations and services in hospitals are likely to continue at today's high levels, a recent survey among small hospitals in all parts of the country would indicate. A number of these hospitals look forward to rate increases in the coming year, it developed in the survey, and none foresaw any possibility that rates could be reduced.

Fifty-five hospitals were included in the survey; they ranged in size from 50 to 110 beds. The average size was 73 beds. Thirteen of the hospitals were in New England, nine were in Middle Atlantic states, 15 were in the Midwest, eight were in the South, five in the Southwest and five in the West. While the number of hospitals, particularly in the last three regions, is so small as to make regional comparisons dangerous, it is perhaps significant that the same variations from region to region emerged in connection with nearly all the charges studied.

The highest charges were found in the New England, Middle Atlantic and Midwestern hospitals; institutions in the South and Southwest had definitely lower rates, while, in this group at least, the Western hospitals were slightly below New England in charges for room accommodations, and somewhat above on service charges.

MORE NEXT MONTH

The study covered rates charged for private, two-bed and four-bed rooms, operating and delivery room and anesthetic service, medications, laboratory and radiological services. The rates charged for room accommodations, operating rooms and drugs are summarized in the accompanying table; summaries of laboratory and x-ray charges will appear in these pages next month.

The average daily charge for a private room in all these hospitals was $11.07. The highest room charge noted was $22.50, in a Midwestern hospital, and the lowest was the $6 rate reported by a hospital in the Southwest. Regional averages ranged from $12.38 in New England down to $8 in the Southwest. Variations in charges for two-bed rooms closely parelleled the private room rates. The highest two-bed charge, $12.50, was in the same hospital that had the highest single room rate, and the lowest charge, $4.50, was in the hospital charging $6 for a private room. Regional variations followed the same pattern as that found in the private room charges. The average two-bed room rate for all hospitals was $8.

One possibly significant change emerged in the summary of rates charged for four-bed rooms; here the highest charges were found in Western hospitals, which averaged $7.94. The average charge for the four-bed accommodation for all the hospitals studied was $6.52. The lowest charge was $3.50, and the highest was $11.

The average charge for use of the operating room during major operations was $22.32; this charge was reported to be as low as $10 in one hospital, and as high as $35 in several others. Regional variations were generally the same as those for room charges, with the exception that in this case the averages for Western and Midwestern hospitals were slightly above the Eastern figures. Minor operating room charges followed about the same pattern, ranging from $3 up to $25 and averaging $11.75 for the entire group.

Ten hospitals in the group indicated that anesthetic charges were made by the doctor administering the service and were not considered hospital charges; several others reported that anesthesia service was charged for according to a sliding scale depending on the length of the operation. Where a fixed fee was reported, it ranged from $10 to $30 for major operations and from $2 to $15 for minor operations. The averages for the entire group were $16.37 major and $9.29 minor. Because of the smaller number of hospitals reporting rates for this service, the regional variations are probably not reliable guides; however, the variations shown are not significantly different from those reported for other services.

Delivery room charges averaged $12.54 for the entire group, ranging from a high of $30 down to a low of $5. Regional variations were about the same as for operating room charges.

DRUG CHARGES STABILIZED

Compared to rates shown in previous studies, drug charges revealed in this survey are fairly well stabilized, with the widest variation naturally shown in the newest drug for which charges were reported, streptomycin. The average charge for parenteral solutions, for example, was $2.47 per 1000 cc.; the lowest charge was $1 and the highest was $5. While this is a 400 per cent differential for the same service, the fact is that 75 per cent of the reporting hospitals charge somewhere between $2 and $3 per 1000 cc. of parenteral solution—not an unreasonable range considering the large number of variable cost factors that enter into the administration of this service in hospitals of varying size and type.

Barbiturates commonly are charged at $0.05 to $0.10 per dose, though a number of hospitals make no separate charge at all and the rate runs up to as much as $0.25 or $0.30 a dose in one or two cases. Charges for sulfonamides and vitamins show about the same range, averaging $0.09 per dose in the first instance and $0.10 in the second. Penicillin charges vary from $0.20 per 100,000 units up to one hospital that is still charging $3, but of the entire group, only nine hospitals charge more than $1. The range on streptomycin is naturally wider, with some hospitals charging as much as $6, $7.50 or even $10 per gram, while others have the charge down to $0.75 or $1.

RATES CHARGED IN SMALL HOSPITALS

REGION	BEDS	SINGLE ROOM	DOUBLE ROOM	4-BED ROOM	MAJOR O.R.	MINOR O.R.	MAJOR ANESTH.	MINOR ANESTH	DELIVERY ROOM	PARENTERAL SOLUTION	BARBITURATES	PENICILLIN	STREPTOMYCIN	SULFAS	VITAMINS	LIVER EXTRACT
										Mcc	Dose	100 M.	Gm.	Tab.	Tab.	Cc.
NEW ENGLAND	46	$12.50	$ 9.00	$ 6.50	$15.00	$10.00	$ 3.00	$ 2.00	$15.00	$1.50	$0.05	$0.50	$1.00	$0.05	$0.05	$0.75
	60	17.00	11.00	10.00	35.00	25.00	—	—	30.00	2.00	.05	.50	2.00	.03	.10	.85
	50	10.00	7.50	6.50	20.00	8.00	—	—	8.00	2.00	*	.50	2.00	.02	.10	.50
	75	13.00	8.00	6.00	35.00	15.00	30.00	15.00	10.00	2.00	.02	.50	1.50	.05	.05	.75
	70	10.00	8.00	7.50	25.00	10.00	25.00	10.00	16.50	1.90	*	.50	3.00	.03	.04	.50
	50	11.00	7.50	6.50	20.00	10.00	*	*	12.00	1.25	*	1.25	1.60	*	*	—
	55	10.00	8.00	7.00	25.00	15.00	—	—	10.00	—	—	.35	1.20	.05	.10	.40
	52	12.00	10.00	—	25.00	10.00	25.00	15.00	15.00	2.00	*	.50	1.00	*	.02	1.00
	73	9.00	7.00	6.50	20.00	5.00	*	*	10.00	1.00	.05	.25	2.00	.03	.03	.45
	104	18.00	13.00	11.00	35.00	17.50	2.00	2.00	20.00	2.25	*	.20	1.30	.03	*	.60
	75	17.00	11.00	8.00	25.00	15.00	*	*	20.00	—	—	.35	3.00	—	—	.48
	83	11.00	8.50	5.00	22.50	15.00	5.00	3.00	12.50	5.00	.25	2.00	6.00	.10	.10	1.00
	55	10.50	8.00	8.00	15.00	5.00	*	*	12.00	1.35	.10	.25	—	.10	.10	.25
AVERAGE	65	$12.38	$ 8.96	$ 7.38	$24.42	$12.34	$15.00	$ 7.83	$14.69	$ 2.02	$0.09	$0.59	$2.13	$0.05	$0.07	$0.63
MID-ATLANTIC	108	9.00	7.50	5.00	20.00	12.50	15.00	12.50	15.00	3.00	*	1.00	5.00	.07	.07	1.00
	70	10.00	7.00	5.00	20.00	10.00	8.00	4.00	12.00	2.50	.05	.40	2.00	*	.35	.25
	58	12.00	10.00	10.00	30.00	15.00	25.00	15.00	20.00	2.50	.05	.30	1.55	.01	.25	.25
	115	11.50	9.00	8.50	20.00	15.00	15.00	10.00	15.00	—	—	.40	2.10	.54	.35	.40
	99	14.00	10.00	—	25.00	15.00	*	*	10.00	—	—	.20	2.00	.05	—	—
	99	10.00	8.00	—	10.00	5.00	10.00	5.00	10.00	2.50	.05	.50	2.00	.01	—	.48
	94	17.50	12.50	9.00	25.00	15.00	15.00	10.00	22.50	—	—	1.25	2.25	.05	—	—
	100	12.00	8.00	6.00	15.00	10.00	10.00	10.00	12.50	3.00	.50	1.50	3.00	—	.05	1.00
	50	9.00	7.50	5.50	20.00	10.00	—	—	20.00	1.00	.05	.70	—	—	—	—
AVERAGE	88	$11.66	$ 8.83	$ 7.00	$20.55	$11.94	$14.00	$ 9.50	$15.22	$ 2.42	$0.14	$0.69	$2.49	$0.12	$0.21	$0.56
MID-WEST	52	9.00	7.00	6.00	25.00	10.00	—	—	7.50	3.50	.04	.55	1.25	.05	—	—
	72	22.50	12.50	9.00	40.00	15.00	15.00	15.00	—	3.75	.20	1.25	10.00	.15	.15	3.00
	53	9.00	5.50	5.00	20.00	7.50	*	*	10.00	2.00	.05	1.00	2.00	.05	.05	.50
	72	12.00	9.00	8.00	27.50	17.50	*	*	15.00	1.50	.04	.50	2.00	.03	.05	.35
	100	13.50	10.00	8.50	25.00	15.00	20.00	10.00	15.00	3.00	.10	1.00	2.25	.10	.10	1.00
	80	9.50	6.50	—	25.00	15.00	25.00	10.00	15.00	2.50	.10	—	—	.05	.05	1.00
	97	11.50	8.00	5.75	30.00	20.00	20.00	15.00	7.50	3.50	.15	.75	2.10	.10	.10	.25
	76	12.00	7.50	6.50	25.00	10.00	17.00	10.00	12.00	3.50	.10	1.25	2.00	.10	.10	.50
	105	10.50	7.25	6.25	20.00	10.00	*	*	10.00	2.10	.05	1.00	4.00	.10	.10	1.00
	50	8.50	7.00	4.50	15.00	7.50	15.00	7.50	12.50	2.50	.05	1.00	1.00	.05	.05	.75
	100	11.00	7.00	5.00	35.00	10.00	—	—	5.00	2.00	.05	1.00	1.75	.05	.05	1.00
	50	10.00	9.00	7.50	15.00	12.50	17.50	12.50	10.00	3.50	—	3.00	4.00	—	.10	.50
	50	9.00	7.00	6.00	20.00	10.00	25.00	5.00	10.00	3.00	.04	.50	3.00	.04	.05	1.20
	85	10.25	7.00	6.50	20.00	10.00	10.00	5.00	10.00	2.10	.05	.50	1.50	.05	.10	.75
	110	12.25	8.00	6.00	25.00	8.00	*	*	10.00	3.00	.10	.50	2.50	.05	.05	.85
AVERAGE	77	$11.33	$ 7.95	$ 6.46	$24.50	$11.87	$18.28	$10.00	$10.69	$2.76	$0.08	$0.99	$2.81	$0.07	$0.08	$0.90
SOUTH	77	12.00	7.50	7.00	25.00	10.00	20.00	10.00	10.00	2.50	.10	.50	2.00	.05	.10	.60
	57	7.00	5.00	4.00	15.00	7.50	—	—	10.00	—	.15	1.00	2.50	—	—	.50
	50	12.00	8.00	6.50	10.00	3.00	10.00	3.00	6.00	2.50	*	*	2.00	*	—	—
	75	7.00	5.00	4.50	20.00	15.00	20.00	15.00	10.00	2.25	—	2.00	5.00	.10	.10	1.00
	62	9.75	7.75	6.75	20.00	10.00	10.00	5.00	15.00	1.50	.10	.75	2.25	.10	*	*
	76	7.00	5.00	3.50	20.00	10.00	15.00	10.00	10.00	2.25	.25	1.00	3.00	.05	.05	.25
	35	9.00	6.50	4.50	15.00	7.50	15.00	7.50	10.00	2.50	—	2.00	7.50	.75	—	1.00
	99	10.50	7.50	6.75	25.00	15.00	25.00	15.00	20.00	2.50	.10	1.00	2.00	.05	.10	.75
AVERAGE	66	$ 9.28	$ 6.83	$ 5.44	$18.75	$ 9.75	$16.43	$ 9.35	$11.37	$2.29	$0.14	$1.18	$3.28	$0.16	$0.08	$0.68
SOUTHWEST	60	9.00	6.50	5.00	25.00	12.50	25.00	15.00	15.00	2.50	.15	1.25	2.10	.04	.05	.50
	99	8.00	6.50	5.00	15.00	7.50	17.00	7.50	10.00	2.25	.30	.75	5.00	.06	.15	.70
	93	9.00	6.00	4.50	20.00	15.00	15.00	7.50	10.00	2.00	.05	.50	.75	.10	—	—
	50	6.00	4.50	4.50	10.00	5.00	10.00	5.00	5.00	—	.10	1.00	1.50	.02	.05	.50
	84	8.00	6.00	4.00	15.00	10.00	15.00	—	10.00	2.50	.10	1.00	3.00	.05	.05	.50
AVERAGE	77	$ 8.00	$ 5.90	$ 4.60	$17.00	$10.00	$16.40	$ 8.75	$10.00	$2.31	$0.14	$0.90	$2.47	$0.05	$0.08	$0.55
WEST	100	9.50	9.00	8.50	20.00	12.50	15.00	10.00	10.00	2.50	*	.50	2.00	*	*	.75
	58	13.50	9.50	7.50	35.00	15.00	*	*	17.50	4.00	.10	.75	3.00	.10	.11	1.00
	52	10.00	8.00	—	22.50	17.50	7.50	10.00	20.00	2.50	.05	.45	4.00	.05	.10	.50
	58	15.00	9.00	8.00	20.00	12.50	25.00	10.00	10.00	4.00	.10	.50	2.00	.10	—	—
	58	10.00	8.50	7.75	25.00	15.00	25.00	10.00	15.00	2.00	.07	.75	3.50	.06	—	.75
AVERAGE	65	$11.60	$ 8.80	$ 7.94	$24.50	$14.50	$18.12	$10.00	$14.50	$3.00	$0.08	$0.59	$2.90	$0.07	$0.10	$0.75
NATIONAL AVERAGE	73	$11.07	$ 8.00	$ 6.52	$22.32	$11.75	$16.37	$ 9.29	$12.54	$2.47	$0.10	$0.82	$2.65	$0.09	$0.10	$0.73

* Included with other charge.

About People

Administrators

Dr. Harold Marks has resigned the superintendency of Community Hospital, San Mateo, Calif., to take a like position with the San Joaquin General Hospital, French Camps, Calif. Dr. Marks is a graduate of the University of Chicago course in hospital administration. **Dr. John Smiley,** who resigned his position as superintendent of the San Joaquin hospital, has not announced his future plans.

Clarence Murphy has accepted the appointment of administrator at Huggins Hospital, Wolfeboro, N.H. He resigned a similar post at Maple Avenue Hospital, DuBois, Pa., and was succeeded there by **Baden J. Thomas,** former member of the board of trustees of Nanticoke State Hospital, Nanticoke, Pa.

Cardon C. Clegg is the new superintendent of Brownsville General Hospital, Brownsville, Pa. His predecessor, **Mrs. L. S. Knuth,** retired recently because of illness after serving the hospital as superintendent for nearly 25 years.

R. D. Powell, former superintendent of Memorial Hospital, Colorado Springs, Colo., has been appointed administrator of Orange County Hospital, Santa Ana, Calif.

Marie M. Behlen has been appointed administrator, Caledonian Hospital, Brooklyn, N.Y., succeeding **R. Arthur Carvolth.** Miss Behlen was formerly director of nursing, Long Island College Hospital, Brooklyn, N.Y.

Brother Ludolph, who has served as administrator of Alexian Brothers Hospital, Chicago, for the last year, has been appointed Provincial of the American Province.

Clifton H. Linville, formerly business manager of St. Monica's Hospital and Health Center at Phoenix, Ariz., is now serving as superintendent of the Yuma General Hospital, Yuma, Ariz.

Charles C. Stewart, acting superintendent of Mercer Hospital, Trenton, N.J., since June 1949, has been appointed superintendent. He succeeds **George H. Buck,** who is now director of the University of Maryland Hospital, Baltimore.

Isabella N. Williams has been appointed administrator of Lake Wales Hospital, Lake Wales, Fla. Miss Williams was formerly administrator of Chenango Memorial Hospital at Norwich, N.Y. Prior to that time she had been successively secretary and assistant to the superintendent of Sinai Hospital, Baltimore; assistant manager and purchasing agent, Doctors Hospital, New York City, and purchasing agent at Michael Reese Hospital, Chicago.


Dr. Julian Priver

Dr. Julien Priver, an assistant director of Mount Sinai Hospital of New York City since 1946, has been appointed associate director of the hospital. Dr. Priver became associated with Mount Sinai after serving his residency in hospital administration at the Hospital for Joint Diseases, New York City.

James McLaughlin, a graduate of the class in hospital administration, Columbia University, School of Public Health, who served his administrative residency at Caledonian Hospital, Brooklyn, N.Y., has been appointed assistant administrator, Conemaugh Valley Memorial Hospital, Johnstown, Pa.

William L. Anderson will assume his duties as head of East Side General Hospital, Detroit, on March 1.


R. C. Magee

Rex C. Magee assumed his administrative duties at Memorial Hospital, Rock Springs, Wyo., December 1. Mr. Magee's previous experience in the hospital field was at the University of Colorado Medical Center, where he served first as purchasing agent, then as assistant business manager, and later as personnel director.

Stephen Pondak, formerly business manager of Millville Hospital, Millville, N.J., has been named administrator of the hospital. A newly created position, it takes the place of the former positions of superintendent and business manager.

Marion Jackson has been appointed administrator, Henrietta D. Goodall Hospital, Sanford, Me. Miss Jackson has been active in hospital circles in New England and is a fellow of the American College of Hospital Administrators.

Dr. Archibald Hoyne, medical superintendent of the Contagious Diseases Hospital, Chicago, has resigned. **Dr. Samuel Hyman,** chief of the communicable disease section of the board of health, has been appointed acting superintendent until the hospital's board of advisers recommends a new superintendent. **Dr. Rowine Brown,** assistant superintendent, also resigned. Dr. Hoyne had been chief of the hospital for 36 years.

Dr. Thomas C. Black, formerly chief of professional services at Lamar Veterans' Hospital, Memphis, Tenn., recently became superintendent and medical director of the Central Florida Tuberculosis Sanatorium.


H. M. Deaner

Haydn M. Deaner has been appointed administrator of Truesdale Hospital, Fall River, Mass., succeeding **Mrs. Delight S. Jones,** who resigned because of ill health. Mr. Deaner served his administrative residency at the George F. Geisinger Memorial Hospital, Danville, Pa., and has been assistant administrator of Truesdale Hospital for the last year.

Mrs. Louise Jones, R.N., has been appointed superintendent of the newly constructed Mauritz Memorial-Jackson County Hospital, Ganado, Tex. The hospital will be ready for use about March 1.

R. Oswald Daughety became administrator of City-County Hospital, Winston-Salem, N.C., December 1. He was formerly administrator of Hermann Hospital, Houston, Tex.

Norman E. Snyder has resigned as superintendent of Gregg Memorial Hospital, Longview, Tex.

A. B. Carter has been named superintendent of the new hospital now under construction at Iraan, Pecos County, Texas. Mr. Carter, who was vice presi-

(*Continued on Page* 156.)

Conducted by Raymond P. Sloan

INDOCTRINATION PROGRAM

acquaints the community with its hospital

A. W. SMITH
Director, Overlook Hospital, Summit, N.J.

WHEN the board of trustees of Overlook Hospital, Summit, N.J., decided to build a new two million dollar private pavilion, it was amazed to find that many friends and supporters knew little about the institution, its organization and function. This caused a great deal of concern and, as we saw it, some quick and concrete explanation had to be worked out on paper and presented to all of the campaign workers telling them about the hospital. This indoctrination story was prepared so that it could best be told to large groups as briefly as possible.

Weekly group meetings were arranged with workers from the various areas served by Overlook Hospital at which time we discussed the plans for the new building, the reasons for them, and the method used by the fund raising organization to raise needed capital. I shall briefly outline some of the methods used in conveying this story.

HISTORY OF THE HOSPITAL

Even though this hospital draws from a population of 191,000 people, many people in communities served by Overlook do not know its location; its size; the work it does; who is affiliated with it; the board of trustees; members of its medical staff; whether it trains interns; whether it has a training school for nurses, and so on.

The hospital was built more than 40 years ago and has played an important part in the community. It was and still is the only hospital available for miles. Since the hospital was founded in 1906 it has grown from a 30 bed private hospital to a community hospital of 200 beds. During this period a modern 41 bed obstetrical unit was built, with a complete operating and delivery room suite, outpatient facilities, modern nurses' home, and extensive additions to the original medical and surgical building.

During the whole talk on the history of the hospital we tried to emphasize the institution's position of leadership: that all during the war it was the front line of civilian defense and that it must at all times stand ready to meet any type of emergency; that it maintains a close relationship with other institutions with which we try to develop better understanding in health and hospital problems and work out uniform schedules and procedures, and what this relationship may mean to us in the future.

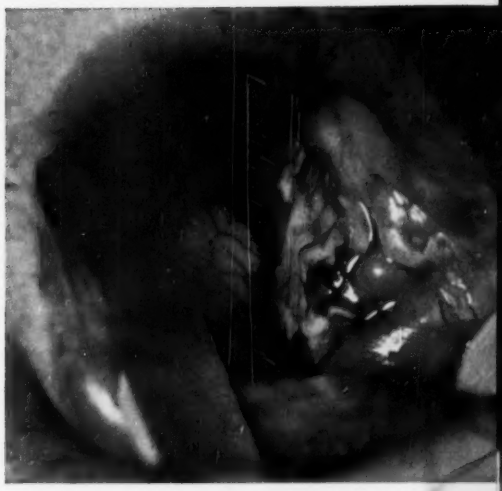
FINANCIAL PICTURE

It was also necessary to bring out the financial aspects of the institution because we were planning to build additions which were more than twice the value of the present plant, and the people of the community wanted to know our financial standing; whether accounts were being paid; the outlook until the new building was erected, and, when the new structure was com-

Picture the patient's progress

. . . with photograph

. . . after photograph

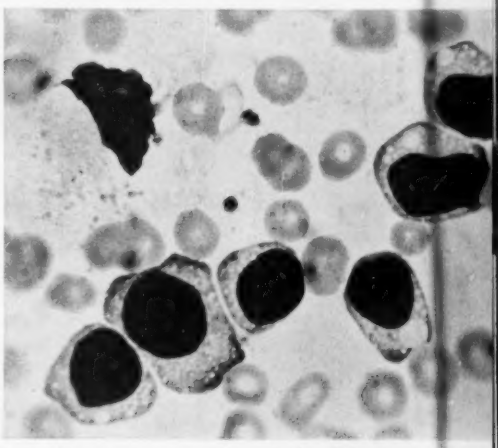


CARCINOMA OF BUCCAL MUCOSA: *Extensive leukoplakia is associated with the primary lesion. (Kodachrome transparency.)*

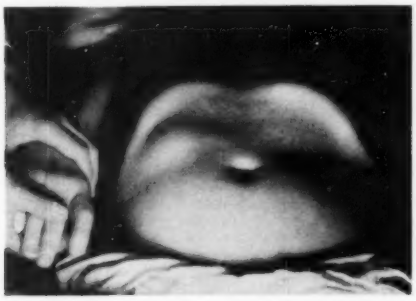
FOR THE BUSY PHYSICIAN, photography can be indispensable. A single photograph, for example, may serve to authenticate a record better than pages of notes . . . a motion picture or a series of still pictures can reach and teach hundreds with the instructor himself miles away.

Full-color photographic studies of oral conditions such as depicted above, of the blood picture at the right, or of the patient below, demonstrate the importance of photography to the individual physician . . . to the profession as a whole. Certainly, nothing else could present the visual aspect of cases like these as forcibly, as memorably, as quickly as Kodachrome or Kodak Ektachrome transparencies.

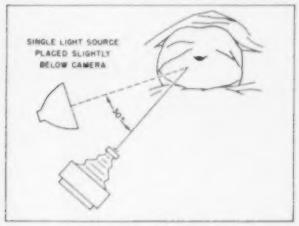
Yet all three photographs — together with others used to document the cases—were the result of simple, routine photography . . . easily, quickly handled with standard equipment and materials by the physician himself, the medical photographer, or a member of the hospital or clinic staff.



LEUKOSARCOMA: *Smear preparation stained to differentiate lymphoid elements in the blood. (Kodachrome transparency.)*



GALLBLADDER DISEASE: *Marked abdominal swelling is evident. (Kodachrome transparency.)*



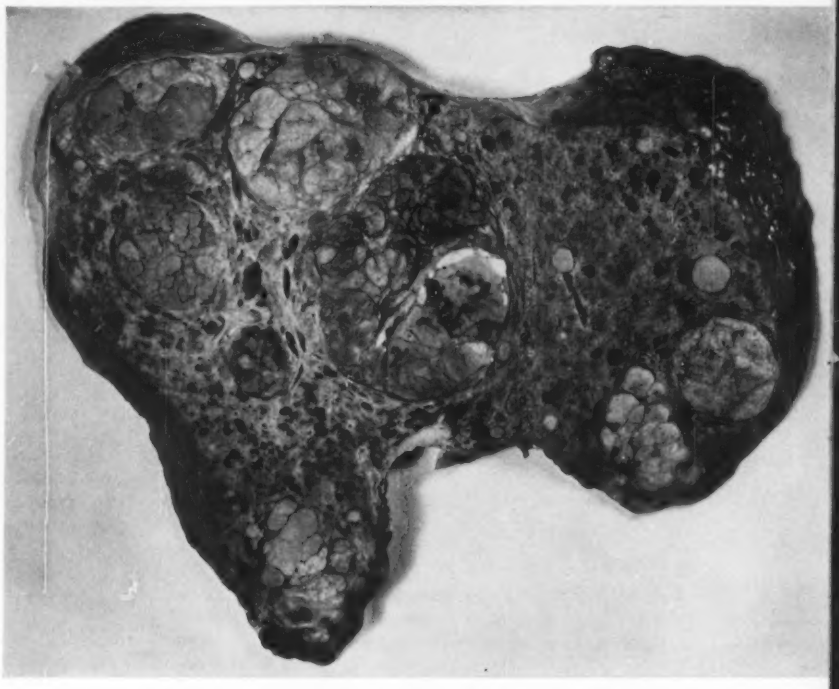
One Kodak Vari-Beam Standlight placed at angle of 30° to the camera-patient axis, affords crosslighting to bring enlargement of abdomen into strong relief.

Serving medical progress through Photography and Radiography

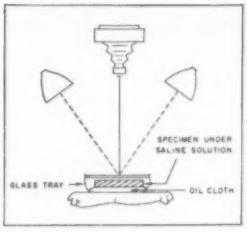
Kodak
TRADE-MARK

Picture the patient's progress *(continued)*

CARCINOMA OF THE LIVER: *This specimen is a section of liver showing the appearance of primary carcinoma. (Kodachrome transparency.)*



To minimize reflections, the specimen was fastened to an oilcloth-covered background, in a glass tray, with a saline solution covering its free surface.



Most cameras become "color cameras"

. . . when they're loaded with Kodak color film

16-millimeter motion-picture cameras use Kodachrome Film in rolls or magazines . . . give duplicates for brilliant showings.

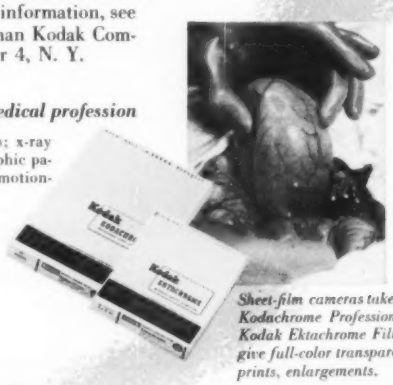
Yes, getting brilliant color is a simple matter with full-color Kodak Film—Kodachrome or Ektachrome. No special equipment . . . no special technic is required for exposure.

With Kodachrome Film, Kodak does the processing without extra charge. Duplicates (same-size, enlarged, or reduced) and Kodachrome Prints are ordered through any dealer. With Kodak Ektachrome Film, processing may be handled in any well-equipped processing room—a tremendous advantage when same-hour results are required. Here, too, Kodachrome Duplicates and Prints are available through dealers. For further information, see your dealer . . . or write to Eastman Kodak Company, *Medical Division*, Rochester 4, N. Y.

Miniature cameras, most of them, use Kodachrome Film . . . give slides for projection, prints, enlargements.

Major Kodak products for the medical profession

X-ray films; x-ray intensifying screens; x-ray processing chemicals; electrocardiographic papers and film; cameras—still- and motion-picture; projectors—still- and motion-picture; enlargers and printers; photographic films—color and black-and-white (including infrared); photographic papers; photographic processing chemicals; synthetic organic chemicals; Recordak products.



Sheet-film cameras take Kodachrome Professional and Kodak Ektachrome Films . . . give full-color transparencies, prints, enlargements.

Kodak
TRADE-MARK

Serving medical progress through Photography and Radiography

pleted, whether we would operate with a deficit or break even or maybe make a profit. This required the compilation of financial statistics which could be easily digested by large groups of people but still convey to them the financial development of the institution, the part it had played in giving service to the needy, and an estimated operating statement to cover the new building plan.

HOSPITAL AND POPULATION STATISTICS

Studies were made to find out how many different areas were served by this hospital. These revealed that our patients are drawn from 34 municipalities. This was most enlightening to all concerned so it was felt that a chart should be prepared which would convey our findings to the general population served by Overlook Hospital. Each municipality was then asked to tell us its present population. A survey of admissions to the hospital for the first six months of 1948 was compiled according to the figures submitted by these municipalities and we then arrived at an estimated admissions figure for the areas served for the entire year. The admission census and population census were set up in chart form.

REVIEWING ORGANIZATION CHANGES

Many changes have taken place at Overlook Hospital in the last two years. Consequently, we felt that we had an opportune time to sell the hospital to the community and to create a feeling of confidence by letting it know that we were well organized. A leading hospital consultant was invited to make a complete administrative survey of the institution. His report gave the board definite and valuable information to strengthen its hand in a reorganization process which was badly needed and long overdue. A survey was also conducted by another consultant to ascertain whether the hospital was properly located in the areas served and whether it should undertake an immediate building program. With these facts and figures before us, we were then able to lay the foundation for an immediate capital drive for a new addition.

One of the most important changes to be made was the hospital by-laws, which, according to modern hospital teachings, had to be rewritten and brought up to date. A great deal of other consultant to ascertain whether new by-laws were approved which specifically set forth the powers of the trustees and the director of the hospital and defined the limits of their authority.

DIRECTORSHIP OF HOSPITAL

Becase there was such a great lack of knowledge as to the functions of the director of the hospital and his relationship with the board of trustees, medical staff and the women's auxiliary, it was felt that a chart of organization should be prepared and presented to the various interested campaign groups. A short résumé was given regarding the present director, where he obtained his training, and what his qualifications are for his present position. Considerable time was spent in discussing the progress made from an administrative standpoint during the last year and a half, and the progress anticipated during the coming year.

COMMUNITY HOSPITAL

Since this is a general hospital serving 34 municipalities, it is a typical example of a community hospital. It was, therefore, necessary to go into detail on what is meant by a community hospital; why it differs from other types of hospitals; its relationship to public health and to industry; what it means to the community; relationship between hospital and director, and the part that the various staffs—attending, courtesy, honorary and consultant—play in our hospital. We therefore prepared a chart which clearly showed the various steps taken by a physician from the time he is graduated from an approved medical school to his appointment on the medical board.

HOSPITAL ORGANIZATION

In order to illustrate clearly the organization existing at our hospital the following charts were made up briefly yet complete in every detail.

1. Overlook Hospital Association. This explains the various steps necessary in order to become a member of the association, election of the board of trustees, officers, relationship with the director, standing committees and their functions, and the tie-in of the women's auxiliary with the board.

2. Overlook Hospital Medical Staff Organization. The purpose of this chart is to show the officers, members of the executive committee, the various committees and sections and their relationship with one another.

3. Organization Chart of Overlook Hospital. A hospital must have sound organization in order to function efficiently. This means there must exist good interdepartmental relationship on the same level of authority, as well as perfect working conditions in the other groups of administration. There must also be a clear picture of the entire setup of the governing body of the institution.

4. Nursing Organization of Overlook Hospital. This chart shows the functions of the nursing department, its relationship to other departments and, finally, the control of the department by the director.

These charts were of material assistance in interpreting the hospital and its organization to the campaign workers and, through them, to the community.

Modern methods of treatment require

AN OPEN PSYCHIATRIC HOSPITAL

D. EWEN CAMERON, M.D.
Director, Allan Memorial Institute of Psychiatry, Montreal

TREATMENT is not only what you do, but where you do it. Medicine has won praise in plenty for great discoveries and inventions in therapy and diagnosis. It would be hard, however, to point to more than a handful of outstanding advances in our provision of places in which treatment may be given. This is particularly true of the treatment of the psychiatric patient. We have the home, the doctor's office, the general and the special hospitals, the clinic and the outpatient department, but these have been with us for periods long antedating the appearance of the great modern advances in psychiatry.

This is a time when we most urgently need new ideas on how to apply what we know. Public opinion has finally been brought to a point where there is the strongest determination to deal with mental health.

PLAN BETTER FACILITIES

In the United States, both federal and state governments have announced extensive plans, well financed, to provide better mental health facilities. In Canada, the Dominion-Provincial health grants, set up last year, go still farther and provide more for mental health than does any other federal government, and at the same time afford greater support to this field than is given to any other health field.

There is a widely held conviction that one form of hospitalization which will be greatly expanded in both countries is that afforded by the psychiatric division of the general hospital. But only too often the planning of these divisions perpetuates a quarter-century old stereotype. Hospital authorities — medical superintendents, heads of clinical departments, chairmen of medical boards— are almost inevitably graduates of 20 or more years ago. When they went through medical school, psychiatric departments in general hospitals were a rarity, set up in a few pioneering centers. Psychiatry was accorded only a few hours in the curriculum of some medical schools, and none in many. A remarkable, but by no means venerable, relic of this neglect is the fact that no separate psychiatric examination is required in the national board examinations in the United States or in the dominion council examinations in Canada, although in both countries approximately one-half of the total hospital beds are occupied by the mentally sick.

TWENTY YEARS OUT OF DATE

Of necessity, then, the psychiatric instruction which these hospital authorities received was based upon the clinical material accessible to the lecturer of 20 years ago, namely, that to be found in the state hospitals. Teaching in those days called for the weekly assignment to the local institutions— the presentation of the demented schizophrenic, the wildly talking manic, and the fearful melancholic, all picked because they were "full blown" cases. So little time was allocated to psychiatry that it was impossible to train the student to recognize any save the gross deviations in behavior, deviations which, incidentally, he might never encounter from one year's end to another when he went out into practice.

Hence, when the student of those days, now grown to the impressive stature of hospital superintendent or member of the medical board, sits down to plan the new psychiatric department, it is this unreal stereotype of 20 years ago that guides his thinking. *In our experience, no fault more frequently mars and distorts the provision of psychiatric facilities in general hospitals than that of planning for the extreme case.*

DOES NOT RESTORE CONFIDENCE

Because 2 to 3 per cent of patients may be actively suicidal, or the occasional patient may be noisy or violent, all the patients must be kept under lock and key; all the windows must be barred or otherwise protected; all the clothing and furnishings must be checked in a vain attempt to eliminate everything with which a patient might make a suicidal attempt. The whole department moves in an atmosphere heavy with conspicuous and uneasy surveillance. Nothing could be less likely to persuade relatives and patients alike of the necessity of seeking early treatment. Nothing could be less conducive to the restoration of the patient's confidence or offer him less fortunate facilities for the regaining of his skills in interpersonal relations.

We would suggest that a much better job could be done if the hospital authority made a clean break with the past (for psychiatry of 20 years ago is the equivalent of pre-Listerian days) and based his planning of the psychiatric section on the needs of that large number of psychiatric patients already in his hospitals—untreated, or erroneously treated—in every department. There is the overconscientious bank clerk whose anxiety is leading to gastric dysfunction; the rigid, tense

spinster who is being treated for stiffness of the neck in the belief that this is "rheumatism" rather than a local expression of the general tension which comes from her struggle to avoid accepting the facts of her own nature; the unnumbered patients who are treated over the years for any single one of the myriad symptoms in which the tensional anxiety and hysterical reactions may manifest themselves, but who, on the general wards, are still only quite rarely treated as people with problems.

He should base himself also on that still larger reservoir of half-well, half-sick people — psychoneurotic, early schizophrenic, depressive — who remain at home or struggle to carry on their jobs because there is no place for them to get the help they need, who crowd the doctors' offices and swamp the outpatient department of every general hospital.

LOCKS AND BARS UNJUSTIFIED

Clearly, if such patients can get along outside the hospital, or can be taken care of in the private section or in the public wards of the departments of internal medicine, surgery and gynecology or any of the specialties—when they are given such diagnostic designations as that of tachycardia of unknown origin, or premenstrual cramps, or when they are operated upon for the removal of an appendix which the pathologists afterwards find is normal—it seems hardly reasonable that they should be asked to enter a locked, barred and stripped-down section of the hospital when they are correctly diagnosed as suffering from an anxiety neurosis or a hysterical reaction.

This is a report of how a psychiatric department in a general hospital has been operated over a five-year period without any legislation empowering the staff to "hold" the patient, or any structural provision to prevent suicides or control impulsiveness other than that existing in any general hospital.

Administratively, the Allan Memorial Institute is an integral part of the Royal Victoria Hospital. Nurses and interns rotate through it. The chief of the department sits on the medical board. The attending psychiatrists act on hospital committees and have a status indistinguishable from that of the attending obstetricians, surgeons and pediatricians.

First, with regard to admission, patients enter the institute on precisely the same basis as they enter any other department of the Royal Victoria Hospital. If they do not wish to enter, they cannot be admitted. Moreover, they (and their relatives) are told that if at any time they do not wish to stay, they will be discharged at once. This results in the screening out of a limited number of patients on the basis of their unwillingness to come to the hospital. The number, however, is remarkably small.

About 50 per cent of the patient population of the institute is comprised of individuals suffering from psychoneuroses. Among the rest are patients suffering from paranoid, depressive, manic, senile, toxic and psychopathic states. Suicidal, impulsive, sexually disturbed, and occasionally violent patients are included in our population.

The doors are not locked, and yet the movement of patients from one ward to another and from the institute into the city is not haphazard or impulsive. There have been three suicides in five years, and no serious injuries owing to violence have taken place. This has been achieved by the application of two general principles:

1. The substitution of the binding power of interpersonal relations for that of physical restraints.

2. Treatment of suicidal trends, active hostility and acute excitement as emergencies.

Binding Power of Interpersonal Relations

Within the first hour after admission we seek to integrate the new patient into his ward group. The head nurse sits down and discusses the hospital routine with him; she introduces him to the other patients, observes to whom he relates himself most easily and, if possible, assigns them to some joint activity. There are no special nurses to isolate the patient in his room away from the ward group. But on occasion the psychiatrist may arrange to have one of the nursing group act as a counselor in a therapeutic team with himself. Joint patient-nurse meetings of the whole group of patients and nurses on a ward are held every day. In these the patients take the lead and the nurses' efforts are directed toward creating a group awareness. Furthermore, many patients belong to group psychotherapy units and also receive individual therapy. And, finally, all patients coming up for discharge take part in discharge group meetings, during which there is discussion of what has been learned and how the individual is going to apply this after leaving.

Instructional and discussion meetings of the medical therapeutic staff and of the nurses are carried on continually, both jointly and separately. Prominent among the fields explored and discussed by the nurses at their meetings is that of the formation and management of groups. Questions such as the following are considered:

1. How quickly can new patients be taken into a group, *i.e.* how many days is it before they seem reasonably incorporated?

2. What are the evidences that a new patient is well incorporated into a group?

3. How many new patients can be introduced at a time into, say, a 10 member group and a 20 member group?

4. What evidence is there of a perpetuation of group traditions, *i.e.* can the nurse identify ways of doing things which persist on, let us say, East-2, regardless of instruction by the nurses? By "persist" is meant regardless of the fact that the composition of the group changes within three to four weeks.

5. How well can the nurses tell when a patient is beginning to break away from the influence of the group? Do patients who are going to run away, or make a suicidal attempt, or steal begin to separate themselves out from the group and break its regulations?

DEVELOP FEELING OF BELONGING

What is the end result of all this determined effort to integrate the individual into the strong group units? The answer is in the first part of this paper, namely, that over the last five years we have treated about 500 patients a year with less trouble than is ordinarily found in the other departments of the general hospital. Patients develop such a strong feeling of belonging to their unit that it is sometimes a problem to get them to transfer to a more convalescent group, and nearly always a matter of difficulty to get them to go home. Many of the former patients of the institute have established an organization of their own which has regular meetings and which brings out a small monthly publication entitled "Insight."

During the first year we had a

cough control

point by point

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problem in that a number of patients returned to their homes in the city and refused to come back to the institute. This was met by developing in the patient body a tradition that it was a coveted and hard to attain opportunity to be accepted as a patient in the institute. Moreover, where a patient had to be committed to a local institution, he was, wherever possible, first discharged home and then committed from there.

The Treatment of Suicidal Behavior, Active Hostility and Excitement as Emergencies

Two main premises guide us in dealing with these acute situations.

1. *The longer they last, the more difficult they are to correct.*

This is in line with what has been reported in military psychiatry, namely, that treatment of acute fear responses is much more successful if carried out within the first few hours or days after their inception than if delayed for weeks or months.

Hence, in the open hospital, we act immediately upon discovery of suicidal behavior, acute hostility or excitement, and we use fast-acting rather than slow-acting agents to break it up. We explore and desensitize under narcosis rather than making use of the slower depth psychotherapeutic technics. We use somnolent insulin—if necessary, continuously throughout the day—rather than hydrotherapy. We use electroconvulsive therapy up to several times a day. Control of food and fluid intake and elimination is taken over within the first few hours, rather than leaving this till dehydration and exhaustion have become clinically evident.

The medical and nursing staff assigned to the patient is at once organized into a psychotherapeutic pattern in accordance with the nature of the problem. If the patient is showing a general excitement, contact is through one member who plays a passive, nonparticipating rôle; if the patient is hostile, contact is commonly maintained through the most accepted member of the team; while in suicide, the group as a whole affords close support and reassurance to the patient.

Under this regime, we commonly find that this acute reaction can be terminated or reduced to easily manageable proportions in 24 to 48 hours.

2. *Our second premise is that all intense reactions affect the other members of the patient group, with a consequent augmentation of the disturbed patient's behavior.*

There is set up, as it were, a reverberatory reaction between the actively disturbed and the other members of his group. Hence, the urgent need to reduce the intensity of his suicidal behavior, his hostility and excitement, and to keep him out of contact with the others of his group until this is done. As will be seen from the description of the procedures used, they naturally entail his being in his room and, commonly, in bed.

If you are planning to open a psychiatric department in a general hospital, here are fundamental "don't's":

1. Do not let it be a "locked" section. After all, the cases that will be coming in are very much the same kind as have hitherto been looked after in the rest of the general hospital.

2. Do not let the courts commit to your center.

3. Do not compromise by opening part of your psychiatric section and locking the rest. This is a half-way device often suggested by overanxious and twittery superintendents of general hospitals. But, paraphrasing Lincoln, "No modern psychiatric division can survive half locked and half open." The patients and the public react to the whole division in terms of the half they fear. And your staff cannot possibly be expected to behave one way inside the locked section and then shift to a modern, progressive pattern when it gets outside the locked door.

AFFECTS STAFF-PATIENT RELATIONS

The major result of setting up a psychiatric section as an open one is the immediate and profound effect upon the staff-patient relations. These relations in an open hospital become greatly enriched and deepened. The staff meets the patient on a person to person basis and not as a semi-deprived citizen. Moreover, the staff is under continual stimulus to understand and help. The patient, too, not being deprived of his status as a citizen, has responsibilities in place of the doubtful privilege inherent in being directed and supervised.

But the main emphasis is upon the great increase in the necessity for the staff to concern itself with, to work upon and to find solutions for the things with which it is faced. You cannot just lock up your problem and go away and leave it.

THE ANESTHETIST NEEDS A NEW NAME

The duties, skills and activities of this specialist are better defined by the designation, "pneumatologist"

PALUEL J. FLAGG, M.D.
New York City

THE most important man in the American community is the patient's doctor — the general practitioner. He is the source to which the individual must turn for guidance. Because of his firsthand knowledge of his patients and of his neighbors, his response to personal and community needs is most likely to be accurate and just.

The doctor's doctor, the specialist, in spite of his identification with physical relief or tragedy, exists to assist and to complete the work of the general practitioner. His function is to provide special diagnostic and technical service to the patient.

MUST CONCENTRATE MORE

To reverse this natural relationship, which occasionally occurs through inadvertence, is to open the door to an appalling assortment of misfortunes ranging from unnecessary operations to sudden death. Human nature being what it is, the progressive specialist in any field may be expected to concentrate upon more and more concerning less and less. The bark of the tree becomes more important than the shadow cast by the forest. If this logic is correct, the inescapable conclusion follows: When one is ill the first man to consult is the general practitioner. He stands at the crossroads. He can best indicate the path that may or may not lead to his associate, the specialist.

The hospital is a community effort to care for its acutely and chronically ill. It is dedicated to the care of all the sick in the community both within and without its walls. Where its services can reach the highway tragedy or the accident in the home, its helping hand is precisely as important as it is in the tonsillectomy, the laparotomy or the bronchopneumonia.

If this community obligation is not realized the hospital can soon deteriorate into a secluded and quite unsupervised experimental station where specialists eager to develop particular fields become intent upon finding material for routine or unusual operations to back up a specialty board standing or a local community reputation.

It may well be asked: Is your hospital designed and operated to provide clinical material for the development of specialties or is it for the purpose of providing service to the patient, services generally recognized as acceptable and safe? That the former frequently occurs is clearly demonstrated in the fact that the new suburban hospital frequently identifies efficiency and progress by the amount and variety of its surgical equipment. The fact that its staff may not be qualified to utilize this apparatus or that, indeed, the new equipment may be a temptation to experimental surgery is quite overlooked.

A question of fundamental importance, therefore, is: What are the clinical experiences of your specialty staff members and, still more important, does your particular community provide enough surgical material of an unusual character to justify the highly specialized procedures contemplated?

Air service is now generally available for the direct transportation of the patient suffering from an exceptional condition to a clinic active in the particular field. Arrangements can also be readily made to transport skilled surgical personnel to the patient who cannot be transported.

Reference to a recently developed and highly specialized field may serve to illustrate the foregoing.

Anesthesia in the suburban hospital has become the center of much controversy. It is implied that the surgical service of the hospital cannot proceed and will shortly collapse if a physician referred to as an anesthesiologist is not employed at the earliest possible date. It is insisted that the specialist in anesthesia is on the same professional level as the internist or the surgeon. However eager and sustained this insistence may be, no matter how necessary and important the contribution to the surgery about to be performed, the fact remains that anesthesia is not an end in itself. The anesthetist cannot exist alone or function alone. He remains and, by the nature of his service, must continue to act as an assistant to the surgeon.

If this be granted, where does the conclusion lead? It would seem to follow that the highly skilled, university prepared anesthetist not only is out of place but must actually remain unhappy and frustrated as assistant to surgeons in a hospital whose activities are necessarily limited to the performance of procedures common to the small community. Trained to meet the exceptional, what scientific relief remains for him but experimentation in novelties?

ROUTINE PROCEDURES SAFER

While highly trained and skillful anesthetists are necessary for a successful issue in the removal of the stomach, a lung, or the short circuiting of the blood vessels of the heart, this exceptional experience and skill are not essential for the great bulk of routine surgery, *i.e.* the tonsillectomy, the appendectomy, the acute infections, the gynecological, genitourinary, orthopedic or other interventions. It is far safer to modify a basically safe, skillfully administered routine of anesthetic agent and method adapted to the age, sex, anatomical, physiological and ordinary pathological variations than it is to attempt to meet these variations by a constant variety in

number and choice of agents and methods.

However, under these conditions a highly trained appointee, even though paid a salary of $10,000, either will be bored to distraction by an acceptable safe routine often carried on best by a properly trained and supervised nurse technician or will be constrained to add flavor and excitement to his approach by trying out everything he knows or hears of—to keep abreast of the time or to keep his hand in for the occasional surgical problem sought out daily in the outpatient department at the request of the progressive surgeon.

As the general practitioner is the most important medical man in the community, and as the specialist in his intensive knowledge of a particular field provides the logical and proper means to the desired end, rehabilitation, an increased respect for the general practitioner and a more intimate and closer association with the field of general medicine would seem to be in order. In the smaller community, instead of disclaiming contact with the patient and with community problems to increase in stature, will not such contact preserve the specialist from the other horn of the dilemma, that of becoming a glorified highly paid technician?

OUTLETS ARE AVAILABLE

The survival of a patient who has experienced an exceptional operation, an operation of choice not an emergency, at the hands of the amateur in a special field does not make such an operator a great surgeon. Mere contempt for the surgical hazard can be confused with courage. While anesthesia parallels surgery under the conditions referred to, legitimate and satisfying outlets for ambition and skill of the physician trained in anesthesia are presently available.

The field of anesthesia is limited by its terminology "the control of pain." The physician, however, practicing in this field is not limited. As a matter of fact he is obliged to make his special skills available when and where required: *Where?* In the emergency care of the unconscious patient outside as well as inside the hospital. *When?* In the event of acute asphyxial accidents. Do these occur frequently? At least 50,000 persons die each year from asphyxia in its many forms, *i.e.* gas poisoning, drug poisoning and industrial accidents; 30,000 of these are newborn babies.* Furthermore, in the hospital where a patient suffers chronic impairment of the circulation and respiration, the anesthetist trained in the pathology of these conditions is likely to be better prepared than is any other member of the staff to render service.

Unfortunately, in the pressure of organizing a new specialty, a singularly successful and skillful accomplishment, the unfortunate designation anesthesiology was adopted. An attempt was later made to decorate the name with new meaning, as resuscitation and inhalation therapy. Since each of these fields is as large as and, in the case of resuscitation, more important to the patient than is anesthesia, it is not surprising that the result has been disappointing.

The restriction of activity and the distress conveyed by the term anesthesiology was noted in the *Journal of the American Society of Anesthesiologists* for September 1949. "The anesthesiologist is obliged to accept the title of anesthetist most of the time because it is shorter and less tongue twisting. Furthermore, in the mind of the general public, the anesthetist, or even anesthesiologist, may mean physician, nurse, technician or even office girl." The *Journal* is to be commended for its candor. It voices hope by explaining that midwifery became obstetrics; unfortunately it does not tell us how or why.

Without in any way disparaging anesthesia and its inestimable value in providing an operative field of new horizons, and with a sincere appreciation of the physician who has done so much in an organizational and technical manner to bring about the present result, the limitation of anesthesia as a restricted intramural specialty serving as an ancillary branch of surgery remains. Conversely, the qualifications and obligations of the physician active in the field should become identified with the larger circle of duties demanding his attention.

Since anesthesia does not provide a common denominator for the three fields of pain control, life saving and the treatment of disease, what remains? In 1798 Sir Thomas Beddoes opened the Pneumatic Institute at Clifton near Bristol in England. In 1929, speaking before a group of anesthetists in Boston, the late Yandell Henderson while discussing resuscitation procedures made this statement, "You men are more than anesthetists, you are gas therapists." The integration was correct, the common denominator, regardless of various other methods employed, is one of gas administration. No question is raised as to the truth of this assertion in inhalation therapy and resuscitation. Although rectal, spinal or intraveneous methods in anesthesia would appear to make the term impractical, the fact remains that the supportive benefit of oxygen, occasionally of carbon dioxide and frequently of the anesthetic gases, must always be at hand.

TERM HAS BEEN ACCEPTED

In 1935 Alexis Carrel, who had become interested in the problem, suggested the use of gases for treatment as "pneumatotherapy." From this suggestion came "pneumatology." The acceptance of this term as an integrating terminology will be found in leading dictionaries and in activities in which the medical service of the armed forces has taken part.

Through pneumatology, the physician director of the medical center and the practicing physician in the community hospital find satisfaction and a man's job capable of absorbing their best training and energy. Because of this enlarged view and responsibilities, the establishment and maintenance of safe anesthetic routines are no longer restrictive. The physician called to care for the sudden asphyxial accident and the chronically ill medical patient once more practices as an independent physician. His position as surgical assistant is recognized as part of other critical duties.

The general practitioner obligated to the patient and to the community will find a capable, experienced, highly skilled associate in the pneumatologist. This associate is prepared to serve him by conducting or directing the anesthesia for his patient, by caring for the inhalation therapy in circulatory or pulmonary complications, and by rendering prompt and expert service in the prevention of impending asphyxia both within and without the hospital. The pneumatologist may be looked upon as one to whom the nurse technician in anesthesia, the oxygen therapy technician in industry, and the rescue squads of the fire and police departments will turn for instruction and supervision.

*Flagg, Paluel J., Art of Resuscitation. New York City: Reinhold Publishing Co.

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THE PHARMACIST STRIVES FOR ECONOMY

IDA GUBER
Chief Pharmacist, Faulkner Hospital, Jamaica Plain, Boston

FOR good hospital management, the director must provide his hospital with a pharmacist. The organized pharmacy can function efficiently in its own specialty and contribute to the welfare of the organization as a whole. This in itself is an economy. Pharmacists are qualified to purchase drugs and pharmaceuticals, and generally do so at a much greater saving than could otherwise be effected. In many instances the pharmacy has been found to be a definite source of income.

SAVES NURSING HOURS

Prompt, courteous service rendered by the pharmacist may result in a saving of many nursing hours when a certain standard of discipline is maintained. Most of us can find ways to improve by studying the situation as a whole. For example, routine ordering, pick up, and delivery service can eliminate much wasted time for the pharmacist as well as the nursing staff. Wherever possible, head nurses should supervise all ordering, anticipating the pharmaceutical needs for their floors for a certain period of time. Messengers can be designated to pick up and deliver pharmaceuticals at specific times during the day. Such routine service would obviously save much of the nurses' valuable time. Of course, emergency orders would be cleared immediately.

Indirectly such service would minimize clerical work for the nurse, pharmacist and bookkeeper. Popular drugs, such as penicillin, can be made floor stock. By floor stock I do not mean the running expense of the various floors. Penicillin should be a charge drug put on a weekly charge basis. For example, the total charges for the number of doses of penicillin received by each patient are sent to the pharmacy once a week; that is, one charge per patient instead of a daily charge. However, if penicillin therapy is discontinued, or if the patient is to be discharged, then the charge is sent to the pharmacy immediately.

It is our duty to uncover leaks and waste in the hospital. This can sometimes result in surprising savings to the pharmacy. Using the aforementioned system along with occasional spot checking of the penicillin drug only on the various floors keeps losses down to a minimum. Statistics have proved this. For example, a 20 per cent loss can be cut to approximately 2 per cent.

The pharmacy and the pharmacist are important good-will agents in every hospital. A clean, neat and well organized pharmacy is an asset to the hospital. With an orderly system, wasted time in locating drugs is eliminated. Such organization also helps the pharmacist keep an adequate, although not excessive, supply of merchandise on hand at all times. The amount saved will depend on the cost of the drugs that are duplicated or overstocked.

Consider the hospital pharmacy as part of the teaching program, always keeping in mind education within the hospital. No service organization can be better than its workers.

Every employe must:

1. Understand his job and what is expected of him. It must be made clear that the employe is expected to do his best and conduct himself in a professional manner.

2. Have an interest in the hospital and understand the policies and purposes of the organization. Make the picture clear to him.

3. Be happy in his work. This is especially important, inasmuch as hospitals depend upon favorable public attitudes.

The interested employe who understands his job is more cooperative with fellow employes as well as the public. He is like a mirror interpreting the hospital to his friends and those coming in for medical treatment.

As a department head, be friendly, enthusiastic and sincere. Establish a training program for the employes of your department. It is a service which pays dividends.

1. Put the employe at his ease, gain his confidence; find out what he knows about the job; point out the importance of the work.

2. Explain major duties carefully and patiently.

3. Allow the employe to try various routine tasks; repeat instructions, if necessary, and criticize tactfully.

4. Let the employe feel free to come to you for help at any time. Observe often; see that the job is being done well. Work simplification is essentially a teaching and training program.

Improved morale makes for a better employe and becomes an indirect economy in the hospital.

TRAIN THEM IN PUBLIC RELATIONS

It is especially important that each and every individual who holds a key position be trained in public relations so that those under his supervision are trained as to the importance of good public relations as well. Good purchasing also makes for good public relations. This type of service cannot be overemphasized because a great deal of thought given to purchasing is a real means of economy to the hospital. The purchasing agent of a hospital does not have to violate any of the rules of good buying in order to build good will; neither does he have to become extravagant in his habits, and in no way does he have to violate his loyalty to the hospital. The pharmacist as a purchasing

Presented at the New England Hospital Assembly, 1949.

agent must be an organizer. Good records and statistics are indispensable. For example, a card index bearing the date, supplier, cost and selling price of each drug stocked provides an excellent source through which to obtain information on various items in a very short time. Such statistics also show up interesting facts, and make it easier to compile reports for the director. Quantity buying based on definite information as to the requirements over a given length of time may be the result of data obtained from this system. The result is economy owing to large-scale buying.

Reputable manufacturers are always glad to present true facts about their products. The more facts you can obtain about drugs and pharmaceuticals, the better your chances for economy buying.

A majority of the suppliers report the need for education of professional people to a better understanding of today's problems of supply. The buyer who is courteous to detail men creates a feeling of cooperation which often results in obtaining scarce merchandise, advance information, or advice of value to the purchaser.

The following are a few of the important points that should be used as guides in dealing with the public or other agencies:

1. Loyalty to the hospital.
2. Justice to those with whom you deal.
3. Faith in your ability and profession.

Buy without prejudice; seek maximum value for each dollar of expenditure.

Promote a spirit of economy in the use of supplies and the proper care of equipment. Slogans that are amusing generally put across an idea more readily than cut and dried "do" and "do not" signs: for instance, "When not in use, turn off the juice."

Drug deterioration, storage space, and price are factors that must be watched constantly. Too much emphasis cannot be placed on a proper turnover of stock; that is, oldest stocks must be used first. Do not permit valuable supplies to grow old and deteriorate in the stockroom. Avoid being penny-wise and pound-foolish.

The competitive spirit among the nursing staff can be stimulated by compiling for distribution analyses of costs of supplies and service for the various nursing units of the hospital.

Demand written orders. Reject telephone orders to prevent misunderstanding and confusion.

The following are suggestions on how to reduce waste in the pharmacy:

1. Drugs should be ordered by a nurse who is carefully instructed in methods for quantity ordering for her particular floor. Unless they are carefully supervised and restricted, many orders may be extravagant.
2. Use such labels as "Expensive drug!" "Please use economically."
3. Dispense eye medicines in small quantities; usually small doses are used.
4. Educate the house staff to use simple U.S.P. drugs, rather than expensive proprietary medicines.

The sale of such articles as paper and cardboard, steel drums, barrels and so on is still another form of economy and sometimes a surprising source of income.

Good workers and good working equipment generally result in good work. Isn't this an economy worth striving for in every hospital?

FROM THE PAINTING BY SAMUEL R. MCDOWELL

COURTESY, AMERICAN COLLEGE OF SURGEONS

Irvin Abell

1876-1949

A graduate of the Louisville Medical College in 1897, Dr. Abell studied in Berlin, Germany, in 1898, and practiced surgery in Louisville from 1900 to 1949. He received Honorary Degrees from six of the leading universities of the United States, was a member and served as President of many of the leading medical and surgical organizations of the United States. He was an Honorary Fellow of the Royal College of Surgeons of England and author of more than one hundred articles published in the medical literature.

During World War I, Dr. Abell was Commander of Base Hospital No. 59 and was Advisor in Medical Affairs to the United States Government during World War II.

A Fellow of the American College of Surgeons from its founding in 1913, Dr. Abell was President—1946-1947, and Chairman of the Board of Regents—1939-1949, and President and Chairman of the Board of Directors, The Franklin H. Martin Memorial Foundation—1946-1949.

From the Series, Great American Surgeons, Published By Ethicon Suture Laboratories, Inc., New Brunswick, N. J.

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Before they are spun into strands, ribbons of gut are soaked in a chrome bath, permitting uniform deposition. Thus, the strand has the same chrome content from periphery to center.

Control of Suture Digestion in Tissue

OPTIMUM RESULTS FROM ETHICON'S TRU-CHROMICIZING

• The ultimate test of the surgical gut suture is its behavior in tissue. Chromic gut is widely chosen because of its prolonged retention of useful tensile strength.

Although the chromic suture must withstand abnormal digestion conditions, the chrome content must not be so great as to prevent digestion. Heavily chromed catgut persists indefinitely in tissue and frequently causes knot extrusion.

To assure uniformity, Ethicon chromicizes gut in the ribbon stage. This exclusive, more meticulous process we call Tru-Chromicizing. An alternative method, used by others, called surface-chromicizing, involves dipping finished, spun and dried suture strands in a chrome bath. These are the usual results of the two methods:

SURFACE-CHROMICIZING

In enzyme solution, or in tissue, the core of most surface-chromicized gut digests readily, leaving a hollow cylinder which separates into ribbons.

This cylinder may be excessively resistant to tissue enzyme action and remain as an undigested foreign body for a prolonged period.

TRU-CHROMICIZING

Ethicon Tru-Chromicized gut exhibits uniform enzyme resistance throughout digestion. It digests from the surface inward, and retains its integrity as a unified suture until dissolution approaches completion.

Total digestion eliminates the danger of knot extrusions and sterile stitch abscesses.

← *CHROMICIZING BEFORE SPINNING*

Ethicon laboratory technician checks ribbons of surgical gut preliminary to immersion in chrome bath for truly uniform chromicization. At Ethicon this process precedes spinning of ribbons into a completed suture strand.

ETHICON
Sutures

ETHICON SUTURE LABORATORIES, INC.
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Good Nutrition..

A VITAL FACTOR IN THERAPY

The sound and wholesome nutritious diet is an integral part of modern day preventive and definitive therapy. A steady stream of adequate amounts of all the essential nutritional elements is vital for good growth, maintenance of tissue structure and functioning, healing after trauma, and resistance to infection. For maintaining this daily, steady stream of nutrients, however, conditions both in health and illness often make imperative the use of an efficient food supplement along with the diet.

The *multiple dietary food supplement* Ovaltine in milk has wide usefulness for enhancing to full adequacy even nutritionally poor diets. Its rich store of vitamins and minerals includes vitamins A and D, ascorbic acid, thiamine, riboflavin and niacin, and calcium, iron and phosphorus. Its nutritionally complete protein has excellent biologic rating.

Since these vital nutritional values along with carbohydrate and easily emulsifiable milk fat are incorporated in liquid suspension or solution, Ovaltine in milk is also especially adapted to liquid diets. The highly satisfying flavor makes for its ready acceptability when foods are often distasteful.

The important nutrient contribution of three glassfuls of Ovaltine in milk is presented in the accompanying table.

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Ovaltine

Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	676	VITAMIN A	3000 I.U.
PROTEIN	32 Gm.	VITAMIN B_1	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

CONTROL OF BODY TEMPERATURE

ONE of the advantages which warm blooded animals in their evolutionary development have gained over their natural environment and lower species is that of being able to maintain a fairly constant body temperature in the face of wide variations in the external environmental temperature. But even homeothermic animals are unable to keep their temperature at exactly the same level and, consequently, normal variations occur throughout the day and in accord with activity. Not only does the temperature of an individual vary throughout the 24 hours, the maximum being in the late afternoon and the minimum some 12 hours later, but the difference between the average daily temperatures of two normal adults may be as much as 2°F. The mean oral temperature at 8 a.m. in a statistical study of 276 medical students was 98.1°F. with 95 per cent falling between 97.3°F. and 98.9° F. (36.3—37.2°C.). A temperature taken rectally is 1°F. above the oral temperature.

Since the central nervous system plays an important rôle in the physiological regulation of body temperature, it is not surprising that the infant during the first year of life is not completely homeothermic and manifests a certain instability of temperature. With the myelination of various nerve tracts, the control becomes perfected.

Regulation of Body Temperature:

The body temperature which any homeothermic animal succeeds in achieving represents an equilibrium among a number of factors, but they can all be grouped under the two main headings: (1) the production of heat, and (2) the mechanisms which regulate the loss of heat. The main sources of heat production in the body are the chemical reactions taking place in the muscles of the extremities and in the liver; hence, this phase is spoken of as the chemical regulation.

Chemical regulation plays a most important rôle in the prevention of hypothermia and is so efficient that it is quite difficult to produce hypothermia in normal man. Low environmental temperatures are a common stimulus to increased heat production. The stimulus acts upon the central thermal centers both directly by cooling of the blood which flows through these centers and secondarily by stimulating the cold receptors in the skin. Heat production is increased by involuntary contraction of skeletal muscles (shivering) and also by the contraction of smooth muscle in the skin resulting in goose flesh and, more important, the decrease of bood supply to the skin by vasoconstriction.

In animals, paralysis with curare causes loss of the ability to maintain body temperature in a cold environment. It is likewise abolished by section of the cord at the level of the sixth cervical segment. The temperature below which the metabolic rate must increase to prevent a fall in body temperature is known as the critical temperature.

Short periods of exposure to cold stimulate the adrenals to liberate secretions which have an immediate but short-lived effect to increase the metabolic rate. The thyroid, on the other hand, is a more important factor in regulating the metabolic rate but acts over a much longer period of time, with several weeks being required appreciably to increase the metabolic rate without an increase in body temperature. The body temperature tends to be subnormal in myxedema, cretinism, and Addison's disease.

The ingestion of protein is a minor factor in increasing heat production. This is the specific dynamic action of food. The increase above the basal metabolic rate is proportional to the amount of protein consumed and is the basis for the recommendation of low protein diets in hot weather and high protein diets in extremely low environmental temperatures.

Although the mechanisms for heat loss are physical in nature, they are dependent for the most part upon physiological adjustments of the blood vascular system. The first of these adjustments is the redistribution of blood from the internal organs to the skin. With cutaneous vasodilatation, a greater volume of blood is brought to the surface for the dissipation of heat. There are four possible ways by which this can be brought about: (1) a change in the temperature of the blood flowing through the thermal nervous centers, (2) central nervous system reflex response to stimulation of hot or cold receptors in the skin, (3) axon reflexes, and (4) response of vessels to direct stimulation by external temperatures.

Blood volume alterations occur with changes in environmental temperature, an increase being noted with a rise in temperature. The blood is diluted by fluid from the skin, muscles and liver. With a fall in temperature, the blood becomes more concentrated. This reaction fails to occur when an animal, rendered poikilothermic by having its cervical cord sectioned, is placed in a cold bath. Third, a moderate increase in circulation rate occurs with an increase in external temperature.

The physical means by which heat is lost are: radiation, convection, conduction, evaporation of water from lungs and skin (including sweating), raising inspired air to body temperature, and the heat removed with urine and feces. At comfortable room temperatures, 70 per cent of the body heat loss is through radiation and convection and 27 per cent through evaporation of water. Radiation and convection cease entirely at 35° C. and at temperatures above that, evaporation of water is the main mechanism.

The body loses heat by radiation only with reference to objects in the environment which are cooler than itself and absorbs heat from objects which are warmer. Convection means the rate of movement of warmed air away from a heated object such as the body. When the temperature differential between the external air and that next to the body is great, convection currents are set up with movement of the warm air and replacement by cooler air. The body loses heat by the constant necessity for warming a fresh supply of air at frequent intervals. Since air is a poor conductor, that means is of minor importance and only occurs when the body is in contact with a good conductor which is cooler.

Sweating as a Safety Valve to Lower Body Temperature:

Insensible perspiration accounts for a constant proportion of heat loss. This term includes the evaporation of sweat before it becomes visible as well as the loss of water from the lungs and from the skin which is independent of the sweat glands. Evaporation of water and sweat accounts for an increasingly greater percentage of the heat lost as the external temperature rises. The efficiency of this mechanism decreases with rising humidity of the atmosphere. Evaporation, like convection, is aided by air movement.

When these means are insufficient to prevent pyrexia, sweating occurs. Sweat glands are innervated by sympathetic fibers, but are anomalous in that they are the only sympathetic nerves in the body which are mainly cholinergic rather than adrenergic. The sweat glands can be directly stimulated by pilocarpine, acetylcholine, epinephrine and muscarine and can be blocked by atropine. The stimulus for sweating is a rise in the temperature of the blood. As a result of emotional factors, sweating can occur in the presence of constriction of cutaneous vessels, *i.e.* palmar and cold sweats.

Nervous Pathways:

The thermal centers which have been mentioned lie in the hypothalamus and have profuse connections with other centers in the reticular substance of the brain stem. The centers controlling heat loss have been identified in the anterior portion of the hypothalamus in the preoptic and supraoptic regions. The main connections are with the parasympathetic system. Lesions in this area in animals cause loss of the ability to resist high external temperatures without developing pyrexia.

In the posterior hypothalamus are situated the centers concerned with maintenance of body temperature on exposure to cold. This is accomplished through the sympathetic system via constriction of cutaneous vessels and contraction of pilomotor muscles. The intermittent contraction of skeletal muscles known as shivering is also a potent heat production system.

It is evident from the numerous factors which have been described that many extraneous influences acting upon different portions of the regulating mechanisms can have similar end effects, namely, a raising or lowering of the body temperature. The effect an agent, such as a drug, will have is dependent in part upon the degree of development of the central nervous system of the animal being tested. Mice and rats will often react to an injection of pyrogens with a fall in temperature in contrast to the pyrexia which is seen in rabbits and man.

Abnormally High Body Temperatures:

Fever is an accompaniment of many pathological processes in animals and man. Toxins from many different sources can stimulate the thermoregulatory centers to cause diminished heat elimination. This manifests itself as cutaneous vasoconstriction and concentration of the blood and is the reason for the chill which often precedes a sudden rise in temperature. The patient feels cold even though his internal temperature is already above normal, because the sensation of warmth which normally exists is due to warm blood flowing through superficial vessels. The coolness of the skin

serves further to stimulate the mechanisms for heat production and shivering occurs. With increased heat production and diminished heat elimination, the body temperature rises rapidly and breaks the spasm of the cutaneous vessels. Now the skin is flooded with blood and the patient begins to feel hot and feverish. The balance between heat production and heat loss is reestablished but at a higher level than normal, and the fever becomes continuous.

The fevers of infants are more extreme than are those of the adult. This is not entirely due to the fact that rectal rather than oral temperatures are recorded, but is due to greater lability of their temperature control mechanisms. In young children, dehydration is a common cause of fever, whereas in later life infections predominate. Moderate rises in temperature are expected in the first two or three days following any aseptic major surgery. This is presumably due to the liberation of toxic material by the damaged tissue. Pyrexia due to injury of the central nervous system is often severe and difficult to control by physical means. Lesions anywhere between the internal capsule and the cervical spinal cord may present this complication. The rise in metabolic rate (7 per cent for each degree of fever) is a result rather than a cause because it cannot be demonstrated prior to the onset of the fever.

Drugs That Raise Body Temperature:

As stated before, it is much easier to induce hyperthermia than hypothermia in a normal individual. Dinitrophenol increases body temperature by increasing the rate of oxidation of fats and carbohydrates. The BMR rises 11 per cent for each 100 mg. ingested. It was at one time prescribed for weight reduction, but proved too dangerous for human use. Atropine produces pyrexia by blocking the cholinergic fibers to the sweat glands. This is a notable feature of atropine poisoning. Thyroxin, given to a normal animal over a period of a week or two, not only raises the temperature slightly, but renders the animal more sensitive to other hyperthermic drugs, such as dinitrophenol.

Drugs That Lower Body Temperature:

Morphine and general anesthetics depress the normal temperature by sedating the thermoregulatory centers. Heat loss is facilitated by cutaneous vasodilatation and an increased blood volume. Alcohol has some sedating action, but has a more marked peripheral effect on the vessels.

There are several drugs which are ineffective in the presence of a normal temperature, hence, they are known as antipyretics. The best known of these is aspirin. The group also includes other salicylates, aminopyrine, antipyrine and quinine. Their mode of action is apparently central. They also have in common the production of hyperglycemia and an increase in blood volume.

Unusual strains in the physical environment can overwhelm the thermoregulatory mechanism, as well as such internal derangements as infections, but for the greater part of our lives it operates with a high degree of efficiency; and as just one of many homeostatic mechanisms it contributes to the stability of the internal environment of which Claude Bernard spoke as being so necessary for the maximal efficiency of cerebral and other body functions.—JULINA GYLFE, M.S.

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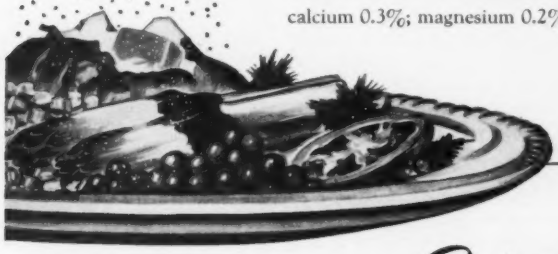

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Conducted by Mary P. Huddleson

FOOD SERVICE IN PSYCHIATRIC HOSPITALS

of the Veterans Administration

PAUL HAUN, M.D.
Assistant Professor of Psychiatry
Georgetown University Medical School
Washington, D.C.

EIGHT psychiatric hospitals ranging in capacity from 500 to 1250 beds were authorized by the President in the 1947 hospital construction program. They were located as follows:

Location	*Capacity*
Pittsburgh, Pa.	1,250
Salisbury, N.C.	900
Gainesville, Fla.	1,000
Toledo, Ohio	1,000
Norman, Okla.	750
El Paso, Tex.	500
Houston, Tex.	1,000
Salt Lake City, Utah	500

Fig. 1.

Six of these upon which construction had not yet started were canceled on Jan. 10, 1949, and the capacity of a seventh, the Pittsburgh hospital, was reduced to 1000 beds. A uniform system of food service was carefully developed for the entire group by the dietetic service in collaboration with the psychiatry and neurology division. National consultants in psychiatry and in dietetics contributed their experience and knowledge and gave unsparingly of their time in the formulation of a final plan, probably the most modern in conception to be found today. Although the same guiding principles were applied to all hospitals regardless of their size, necessary adjustments for the 500 bed installations leave unanswered certain of the problems met with in those of greater capacity. The discussion will, accordingly, be confined to the 1000 bed hospital.

Seven bed-containing structures are provided according to present standards. There are, of course, additional buildings used in the therapeutic programs of tranquilization, resocialization and emotional reeducation. These, along with service buildings and personnel quarters, constitute the hospital as a unit.

The bed-containing buildings are listed below:

Building	*Capacity*
Admission and treatment	170
General medical and surgical	245
Disturbed	120
Infirm	100
Continued treatment (three in number)	160 each
Total	1,115

Fig. 2.

They fall naturally into two principal groupings, those concerned with the active treatment of acute disorders (general medical and surgical and admission and treatment buildings) and those in which long-term therapy will be administered (the continued treatment buildings, the infirm building and the disturbed building). Contact between the acutely and chronically ill patients should be minimal, and physical separation of the two mentioned groups of buildings has been effected within the limitations of the selected sites.

An important reason for establishing the total bed capacity of the hospital at the indicated figure was to permit the proper diagnostic classification of patients by building and by nursing unit without making the latter too small for efficient personnel utilization or too large for satisfactory professional supervision.

The function of each bed-containing building can be summarized as follows:

Admission and Treatment Building—170 Beds

All incoming psychiatric patients will be admitted first to this building for detailed examination, classification and intensive therapy. Patients with favorable prognosis will be treated here for periods of four to six months in the hope that a return to the community can be effected without the necessity of transfer to other wards of the hospital. Seven nursing units will permit a high level of differential classification by behavior and by sex. Patients from this building will make full utilization of facilities in the adjunct patient buildings: recreation, medical rehabilitation, gymnasium and theater. Patients with unfavorable prognosis whose improvement under active treatment is improbable will be transferred within short periods to an appropriate building for long-term therapy.

General Medical and Surgical Building—245 Beds

This will be a general medical and surgical building of 245 beds, 180 of which are devoted to the cure of nonpsychiatric medical and surgical patients who enter the hospital for treatment of such disorders as pneumonia and appendicitis. Such patients will be mentally competent in every respect. In addition, two separately designated nursing units will care for the physically ill among the psychiatric population of the station. Ambulant patients of the hospital, psychiatric as well as nonpsychiatric, will be served by outpatient clinics.

Disturbed Building—120 Beds

Patients cared for in this building will be chronically disturbed, periodically uncooperative, and assaultive on occasion. Suicidal tendencies will be common and exceptionally close supervision will be necessary. Although most of their activities will be centered in their own building, groups as well as individual patients will be frequently taken to the outpatient clinics in the general medical and surgical building, and to the adjunct patient buildings previously listed.

Infirm Building—100 Beds

This building will house elderly,

This is the first section of Dr. Haun's article on food service in the psychiatric hospitals of the Veterans Administration. The second section will appear in the March issue of this magazine.

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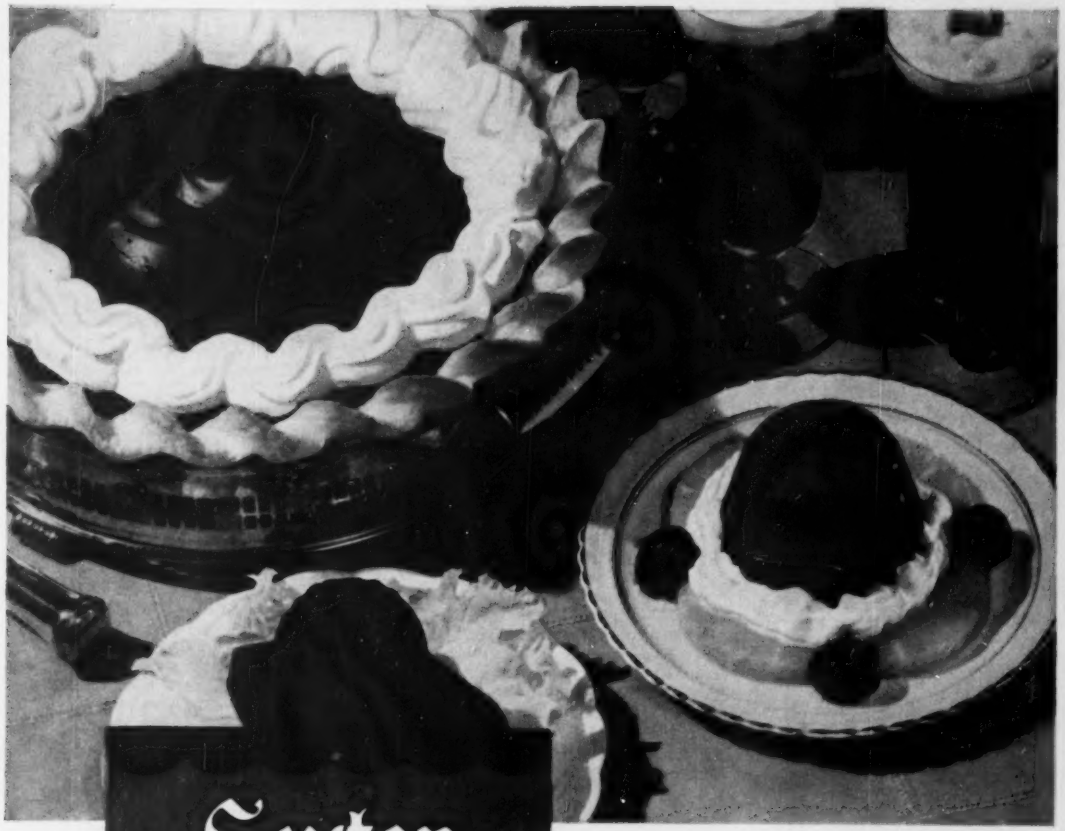
It's the dessert that makes the meal! And for quick, economical, inviting desserts, there's nothing like Sexton gelatine dessert . . . or Sexton chocolate dessert. So easily prepared! So many delightful ways to serve them . . . each one smooth, flavorful, alluring to the eye. Wholesome and delicious for young and old. Serve them often.



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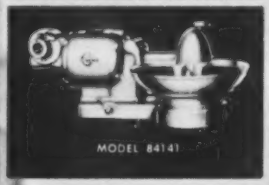

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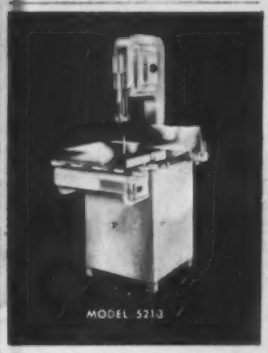

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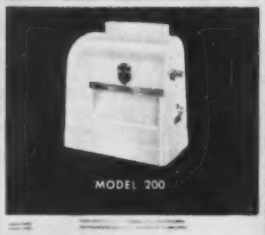

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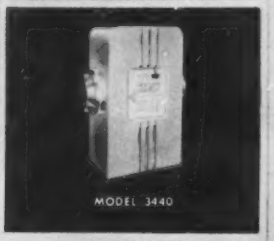

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feeble or physically incapacitated patients whose relatively static disabilities are too chronic to warrant care in the general medical and surgical building. Certain of them will be bedfast and others will require wheelchairs. Most of their activities will be centered in their own building, but groups as well as individual patients will not infrequently be taken to the outpatient clinics in the general medical and surgical building, and to the adjunct patient buildings previously listed.

Continued Treatment Building —160 Beds each

Patients cared for in these buildings will require hospitalization for long periods of time, many of them permanently. They will, in general, be orderly, reasonably cooperative, and in good physical health. All will be ambulant. Many will be engaged in various aspects of hospital industry, and some will have the freedom of the hospital grounds. Large numbers will employ the facilities of the adjunct patient buildings: recreation, medical rehabilitation, gymnasium and theater.

GOALS OF THE PLAN

Here, then, was the dietetic problem to be solved. How could 1100 patients with markedly differing behavioral characteristics grouped in the seven indicated buildings be most satisfactorily fed? There was immediate recognition of the humanitarian iniquity, the medical stupidity, and the economic folly of a program which limited itself only to the provision of sufficient calories to keep patients alive. The planning groups chose rather, within the economic and administrative framework of the construction program, to orient their proposals directly to the essential purpose of the hospital. One question was asked before any concrete suggestion received further consideration: "Does this proposal make a significant contribution to the welfare of the patient?" Approval of any measure not in accord with the totality of patient needs was withheld.

Because the importance of food in therapy and the significant rôle played by the dietetic service in the effective discharge of the hospital's mission were fully realized, certain minimal requirements were initially established fundamental to good dietetic practice:

1. Food must be freshly prepared, appetizing and nutritious.

2. The three daily meals must not dislocate the many therapeutic programs of the hospital.

3. The patients' surroundings during the meal hour must be quiet, pleasant in nature, cheerful and tranquilizing in their effect.

4. Dining rooms must be readily accessible to patients and personnel.

5. Demands on nondietetic hospital personnel that accompanies patients to and from dining rooms and aids in supervising their meals must be held to an absolute minimum.

6. The professional or semiprofessional status of all hospital personnel must be recognized in the caliber of the staff food service and the appointments of all personnel dining rooms.

7. Optimal working conditions for dietetic personnel must be ensured through careful attention to the location of kitchens, dining rooms and storerooms; to the efficient placement of roads, tunnels, service entrances, elevators and dumbwaiters; to the quality of all equipment, and to its proper location in functionally interrelated areas within the several buildings.

8. Budgetary realities must be clearing understood from the standpoint of the capital investment in the physical plant and the annual operational expenses to be anticipated during its life.

9. The total food service plant must be designed for operation by the smallest possible staff.

Theoretical considerations regarding the claimed "efficiency" of centralized food service, the personnel implications of auxiliary kitchens or the alleged economies of multiple seatings were found to have lost cogency or to have acquired new and surprising significance when tested against the explicit aims of the program. No single method of food service met in a satisfactory fashion all of the requirements. A patient who had just undergone a gastric resection was hardly a suitable candidate for a cafeteria line. The social tendencies of a middle-aged schizophrenic who had never had a physical indisposition in his life were not combated by a bedside tray. The needs of the post-encephalitic were met by neither a cafeteria line nor a food cart wheeled to his bedside.

It soon became apparent that the provisions for food service along with the other therapeutically significant structural components of bed-containing buildings had to be individually adjusted not only to the over-all design and function of the hospital but to the specialized requirements of the patient groups contained in individual buildings. An over-all solution could be obtained only by resolution of the problems of individual buildings, and an appropriate plan for the individual building could be arrived at only through careful coordination with the total scheme.

ADMISSION AND TREATMENT

Although the patients in the admission and treatment building would differ in age, in sex and in the nature of their disorders, they would, for the most part, share one thing in common—a favorable prognosis. Here the diversity of therapeutic efforts would be widest. Here the most concentrated attempts at rehabilitation would be focused. Every appropriate treatment measure at the disposal of the hospital would be promptly brought into play in a determination to return the patient to society within a maximum of six months. Facilities would be arranged for the maximum convenience of the staff so that its efforts might be devoted without interruption to the largest number of patients. Leisurely trips to a common dining room necessitating the protracted absence of patients and personnel from the nursing units would not be feasible, nor would it be medically defensible to seat a convalescent about to be discharged alongside an acutely agitated patient newly admitted to the hospital. Dining rooms would have to be small and conveniently located; the food in its flavor and the tastefulness of its serving would necessarily reflect the concentrated determination of the entire staff to leave nothing undone for the patient's benefit.

There can be little doubt that the palatability of food stands in inverse ratio to two factors: the quantity initially cooked and the time elapsing before it is served. I am well aware of the merits of heated food carts and steam tables; of the helpful technics for continuous cooking in large institutional kitchens. The great accent placed on these shifts and dodges, the never ending effort to improve them, affords the greatest possible confirmation of the basic fact: the less one cooks and the quicker it is served, the better it tastes.

(*Continued on Page* 108.)

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Gentlemen:

Recently we opened our new restaurant and it was necessary to secure a complete new dinnerware service. After talking to some of your Jade-ite users and making a thorough investigation, we decided to buy your heat-proof Jade-ite restaurant ware.

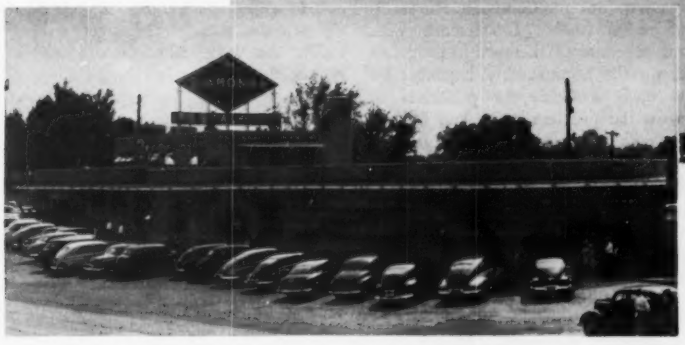
Some of the determining factors were eye-appeal, initial and replacement cost, durability and the ease with which the ware can be kept clean and sanitary. All of these things are very important to us because in our operation we feed over a million and one-half people a year. Catering to such large crowds, we have proved to ourselves that Jade-ite is durable, stain-proof, easy to clean and keep clean and most economical to use. We have served as high as thirty-thousand people over a three-day weekend, which taxes our facilities to the utmost, and it is then that the use of Jade-ite with it's serviceability and low cost is really appreciated.

We can truthfully say that we have found no fault whatsoever with the Jade-ite service and have received many fine compliments as to the appearance of your service.

We are pleased to recommend Jade-ite Fire-King restaurant ware.

Yours very truly,

THE DIAMONDS
Louis B. Eckelkamp



A HALF ACRE OF HOSPITALITY

The Diamonds, known from coast-to-coast, on U.S. Highway 50–66 and Mo. 100, serves over one and one-half million people a year. When *The Diamonds* invested $350,000 in a rebuilding program, they insisted that every item be in the best of taste and of the highest efficiency. They chose JADE-ITE FIRE-KING Restaurant Ware.

In order to reduce the load on the main facility, an auxiliary kitchen was specified for the admission and treatment building. Here all the food for 170 patients will be *cooked* with the exception of such basal items as bread, pastries, soups and meat stocks and such particularly perishable items as toast and eggs. Since centralized food *preparation* offers unquestioned advantages in the efficient utilization of space and personnel without impairing the resultant flavor of the food, meat cutting and vegetable preparation are not to be done here but in the central hospital kitchen.

Three serving kitchens were planned for the building. Here cooked food received from the auxiliary kitchen by heated cart and dumbwaiter will be served over cafeteria counters to the two adjoining dining rooms. Here, too, fresh coffee will be brewed, eggs will be fried, toast will be prepared, and other appropriate foods will be cooked and immediately served. For the few patients who, on occasion, may be unable to take their meals in the ward dining room, a cart will be charged in the serving kitchen and bedside trays will be distributed to the two nursing units served.

Fig. 3—Dining Facilities in Admission and Treatment Building

Nursing Units	Beds	Ward Dining Room Seats	No. of Pts. at Each Table	Full Cafeteria Service
Parole	20			
Convalescent	28	48	6	48 pts.
Quiet and suicidal	22	22	4	22 pts.
Observation	28	28	4	28 pts.
Disturbed	22	22	4	22 pts.
Women's Quiet	28	28	4	28 pts.
Women's Disturbed	22	22	4	22 pts.
Total	170	170		170

BREAK WITH TRADITIONS

Cafeteria service for all dining rooms of the building was chosen in order to accent the patient's individuality by permitting him to choose the quantity and type of food he preferred. Although recognized as a break with the grim traditions of the past, there was abundant evidence that the patient's psychiatric condition in itself rarely constituted a bar to his creditable discharge of the small responsibilities of the cafeteria line.

The cafeteria system afforded another great advantage — that of breaking up a number of medieval hospital traditions directly taken over from the almshouse. It is the unhappy custom in many psychiatric institutions to "set the table" well in advance of the meal. To the happily ignorant layman this may have connotations of damask and crystal, of carefully folded serviettes, and exact rows of polished table silver. To the hospital attendant it means slices of bread drying on the table while someone sweeps the dining room; it means a single heavy spoon at every place; butter rapidly melting in its own grease; salads wilting into indistinguishability with their thin dressing; dust clouds settling on 18 ounce coffee cups, and a few flies crawling over the soggy fruit of an upside-down cake.

An hour, an hour and a half, perhaps two hours later the meal begins. To the stale odors and rancid tastes of the refectory are added the dubious skills of patient-waiters transporting plates hastily filled with the unvarying specialty of the day, their thumbs at times in the beets and their neck-ties in the congealing gravy; the year-long monotony of tepid coffee always containing an exactly calculated quantity of cream; the traditional urgency to eat and have done, so that Ward B and later Ward C may occupy the seats.

Opinion polls were conducted among dietitians, and the experience of hospital superintendents familiar with single and multiple seating in psychiatric dining halls was carefully weighed. Thorough scrutiny of the facts led to provisions for single seatings throughout. With a seat for every patient, service is unhurried, and all patients eat at clean tables in a clean dining room. Meals may be served at normal intervals and not overlap into mid-forenoon and mid-afternoon hours. Interference with the schedule of therapeutic programs is thereby minimized. Adequate time is made available for personnel to assist the problem eaters and for the patients to select the kind and amount of food desired. Slow eaters are no longer penalized, and the confusion and disorder caused by the continuous clearing of tables and cleaning of the dining room during meal periods are eliminated.

More satisfactory working conditions raise the efficiency and the morale of dietetic personnel. Maintenance costs are definitely lowered with reduced dish breakage and damage to equipment. There is noteworthy improvement in the palatability of food which can be prepared immediately before mealtime and served while it is still in optimal condition. With multiple seatings food must either be kept for long periods on the steam table, with marked impairment in flavor, or freshly cooked under hurried conditions by a depleted dietetic staff already involved in serving, cleaning and dishwashing activities. Table manners among patients show improvement, and there is an increased tendency toward resocialization. A part of these direct patient benefits may result from better supervision by the dietitian made possible through an efficient and orderly plan of food service.

Even in those instances where single seatings are possible, institutional habit doggedly provides the long table, the endless, orderly anonymous rows of seated patients elbow to elbow, thigh to thigh. Can it be that on some atavistic, jungle-spawned level of our personalities we dare not think of the psychiatric patient as a human being? Can it be that somehow, someway we must blur and dehumanize him, give him a number, place him in a line, dissolve his individuality into the mass? The vigor with which the long table is defended against the manifest and self-evident advantages of one seating only four points strongly to the possibility of unconscious and irrational motivation.

Last, it was recognized that the appointments of the dining room were of signal importance. A wide expanse of windows was recommended, colorful draperies, pleasantly tinted walls and a cheerfully patterned floor were encouraged.

Figure 3 summarizes the provisions.

GENERAL MEDICAL AND SURGICAL BUILDING

As in the building just discussed, a markedly diversified group of patients will be cared for in the general

medical and surgical building. Some will remain in hospital for a few days, others for decades. Although the majority will be nonpsychotic, some 25 per cent will suffer from mental illness associated with a serious physical disorder. Such patients will require not only skilled psychiatric management but careful attention from the internist and surgeon. The presence of female patients and those with communicable diseases will further increase the diversity of the dietetic problem.

The percentage of patients requiring bedside trays will be variable and will change from week to week depending upon the shifting diagnostic complexion of the patient census. Because of the therapeutic importance of early ambulation and the medical significance of resocialization and group participation, it was decided to base the seating capacity of dining rooms on *peak* rather than on average loads. As a result, the hospital will not have to keep any patient on tray service because a seat for him is unavailable in an appropriate dining room.

Psychotics should not, of course, share a common dining room with nonpsychotic patients, but the provision of a separate dining room for each of the 30 bed psychiatric units in the building contributes nothing essential to patient care. From the psychiatric standpoint there is no objection to the mingling of such medical and surgical patients during the meal hour. It is entirely feasible for a psychotic with cirrhosis to eat with another who has just undergone a herniotomy. Where the classification of nursing units is based on psychiatric considerations, as in the admission and treatment building, separate ward dining rooms are provided. Where, as in the general medical and surgical building, the ward classification relates to the patient's physical disorder, not his psychiatric condition, these are unnecessary.

It is true that a dining room communicating directly with each nursing unit would simplify the supervisory tasks of the ward personnel, but this gain is not sufficiently great to justify the more elaborate architectural plan.

An auxiliary kitchen is specified for the building, based on the same reasoning that led to its inclusion in the admission and treatment building. An important additional justification is the frequency with which special diets will be prepared for patients suffering from diabetes, uremia, pernicious anemia, and so forth.

Serving kitchens are located on all nursing floors and are connected with the auxiliary kitchen by elevator and dumbwaiter. These will permit the cooking of perishable foods and will allow individual patient trays to be set up and distributed on the same floor with the related nursing units. Only one of the serving kitchens is associated with a dining room, that on the psychiatric floor.

The majority of the plans permit the common dining room for general medical and surgical patients to be intimately related to the auxiliary kitchen itself, so that only a cafeteria counter and back bar are required in this location rather than the more elaborate equipment of the serving kitchen.

Full cafeteria service is provided in the common dining room for general medical and surgical patients, with seating for 100. Waiter service was not considered desirable because of its greater expense, the increased likelihood that hot foods would cool before patients received their plates, and the almost insuperable difficulties which would result from allowing individual choice as to the quantity and nature of food selected. The cafeteria line will also provide an indirect but useful incentive to the physically handicapped in the field of the simpler motor skills. For the wheelchair and crutch patient, auxiliary waiter service is contemplated.

The maintenance of isolation technics and the dangers of cross-infection left bedside tray service as the only sensible choice for the small communicable unit.

No special provisions will be made for the 10 bed women's unit on the assumption that the hospital superintendent will administratively determine whether ambulant patients are to eat in the common general medical and surgical dining room or from bedside trays. Nonambulant patients will receive trays from the serving kitchen supplying the men's nursing units on the same floor.

Forty seats are provided in the psychiatric dining room on the assumption that never less than 20 patients on the two nursing units served will require bedside trays. In spite of its intrinsic defects, waiter rather than cafeteria service was chosen for several reasons. Chief among these was

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Fig. 4—Dining Facilities in General Medical and Surgical Building

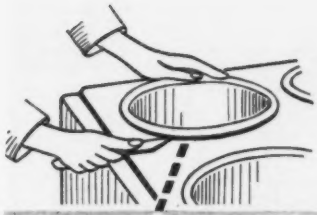
Nursing Units	Beds	Ward Dining Room Seats	Common Dining Room Seats	No. of Pts. at Each Table	Full Cafet. Service	Waiter Service	Bedside Tray Service
Medical	40						
Medical	40		100	6	100 pts.		60 pts.
Surgical	40						
Surgical	40						
Women	10						10 pts
Isolation	10						10 pts.
NP Medical	30	40		4		40 pts.	20 pts.
NP Surg.	30						
Total	240	40	100		100	40	100

the fact that the inevitable errors of judgment to be anticipated among psychiatric patients will have more serious consequences when associated with major physical infirmities than when occurring in a group of physically healthy individuals. An altercation, a fall, an overestimation of present physical strength, an indiscretion in the quantity of food consumed may, in a moment, undo weeks of effort by the professional staff. With adequate personnel, supervision can be closer and control more effective with waiter than with cafeteria service. It will be the responsibility of the professional staff of the hospital to make sure that the traditional abuses potential in this type of food service are avoided.

In this connection it may be said that in setting up the varied structural provisions of the complete food system, the responsible planning groups were not naïve enough to believe that defects in operation and abuses in utilization could be corrected by mechanical means alone. There is nothing about a cafeteria that ensures the millenium; nothing intrinsic in table service that precludes the considerate treatment of patients. The planners were keenly aware that good medicine is achieved by education and not by legislation; that the manifold implications of successful therapy relate more to human beings than to humane architecture. They were well aware that sickness had been cured in tents, pain relieved in log cabins, depressions eased on straw pallets, and pus drained by kitchen knives. They also knew that these victories were won, not because of but in spite of the associated physical handicaps. In its deepest sense the planning was based on faith and belief: faith in education, and belief that the best of intentions may eventually be blunted by material obstacles; faith in eventual victory for the professional point of view, and belief that ingenuity and the gadget *can* make their own contribution to human welfare.

Ample circulation space was recommended for the two patient dining rooms. Tables seating six were specified for the general medical and surgical cafeteria. In the psychiatric dining room this was reduced to four so that no patient would be crowded and the staff would have complete freedom in assisting handicapped individuals with their meals.

The provisions for the building are charted in Figure 4.



No Knife-Scraping Needed

. . . BECAUSE THERE ARE NO CREVICES

ORDINARY CONSTRUCTION
showing food conveyor top with crevices around each well.

Seamless, sanitary top eliminates dirt-collecting crevices on all Blickman-Built Food Conveyors

BLICKMAN SANITARY TOP
showing smooth, continuous surfaces where wells meet top deck. Cleaning is simple and quick. There are no crevices where dirt can lodge.

● In ordinary food conveyor construction, wells are separate units, forming crevices where edges are joined to top deck. These crevices form natural traps for food and dirt particles. Usually, adhesions can be loosened only by scraping with a knife or other sharp instrument. Even then, deposits can't be completely removed. It is impossible to achieve real cleanliness. Extra time and labor are required every time the conveyor is cleaned.

Blickman's new seamless top construction, however, permits thorough sanitation. Round and rectangular wells are *actually part of the top deck.* Where edges of the wells meet the top, they form *smooth, continuous, crevice-free surfaces.* There are no recesses where dirt can lodge. Cleaning is quick and easy. Just wiping with a damp cloth keeps the highly-polished stainless steel surfaces bright, clean-looking, sanitary!

SEND FOR *New* VALUABLE BOOK
Describing complete line of Blickman-Built food conveyors, including the widely-acclaimed selective-menu models. Contains detailed specifications.

Blickman-Built food conveyors alone offer the seamless, sanitary top as standard construction. Investigate this—and other essential features, before you buy your next food conveyor.

the *New* Selective Menu Food Conveyor

One conveyor now gives you a great variety of inset arrangements for your selective menus. Interchangeable square and rectangular pans can be placed in the rectangular wells in different combinations. Round wells are used for soup or other liquids; two heated drawers for special diets. There are many other interesting features—write for complete information.

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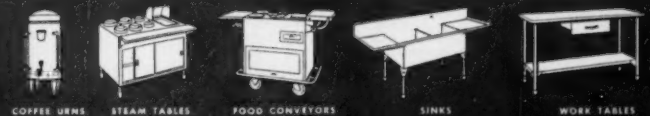
Blickman-Built
FOOD SERVICE EQUIPMENT



Menus for March 1950

I. Mansour
Hotel Dieu
New Orleans

1
Orange Juice
Scrambled Eggs
•
Okra Gumbo
Broiled Salmon Steaks, Lemon Butter Sauce
Baked Potatoes
Buttered Whole Green Beans
Sliced Tomato Salad
Lime Chiffon Pie
•
Vegetarian Vegetable Soup
Toasted Cheese Sandwich
Celery, Pickles, Olives
Apple Goody Pudding

2
Sliced Bananas
Bacon, Date Muffins
•
Potage à la Reine
Roast Prime Ribs of Beef au Jus
Crusty Potatoes
Glazed Whole Carrots
Head Lettuce, Roquefort Dressing
Stuffed Angel Food
•
Barbecued Spareribs
Corn on the Cob
French Bread
Tossed Salad
Fruit Cup, Cocoons

3
Apricot Nectar
Poached Eggs, Toast
•
Cream of Celery Soup
Shrimp Creole
Steamed Rice
Buttered Broccoli
Apple and Grapefruit Pinwheel Salad
Pineapple Sherbet
•
Mushroom Omelet
German Fried Potatoes
Buttered Green Asparagus
Sliced Cucumber Salad
Raspberry Cake Pudding With Whipped Cream

4
Stewed Prunes
French Toast
•
Fruit Juice Cocktail
Trout Amandine
Parsley Buttered Potatoes
Fresh Frozen Spinach With Egg
Jellied Bing Cherry Salad
Banana Pudding
•
Cream of Pea Soup
Cottage Cheese Salad
Potato Chips
Sliced Tomatoes
Peach Turnovers

5
Grapefruit Juice
Link Sausages
•
Essence of Tomato Soup
Fried Chicken
Buttered Frozen Lima Beans
Parslied Carrot Circles
Buttered Hot Rolls
Blush Pear Salad
Butterscotch Sundae
•
Chile Con Carne With Red Beans
Cheese and Crackers
Coleslaw
Fruit Gelatin
Sugar Cookies

6
Frozen Sliced Peaches
Fried Eggs
•
Alphabet Soup
Veal Cutlet Fromage
Italian Noodles
Stewed Squash
Rolled Lettuce Salad
Pineapple Upside-Down Cake
•
Liver With Onions
Baked Grits
Buttered Green Peas
Hot Biscuits
Frozen Cheese Salad
Blackberry Dumplings

7
Tomato Juice
Canadian Bacon
•
Black Bean Soup
Stuffed Pork Chops
Orange Sweet Potatoes
Buttered Brussels Sprouts
Cinnamon Apple Salad
Oatmeal Mincemeat Squares
•
Hot Beef Sandwich
Whipped Potatoes
Buttered Green Beans
Combination Fruit Salad
Chocolate Ice Cream With Marshmallow Sauce

8
Tokay Grapes
Shirred Eggs
•
Crawfish Bisque
Broiled Flounder, Lemon Butter Sauce
French Fried Potatoes
Cauliflower With Cheese Sauce
Head Lettuce, Russian Dressing
Cherry Tarts
•
Fried Oysters With Tartare Sauce
Macaroni and Cheese
Broiled Tomato Slices
Avocado and Grapefruit Salad
Baked Caramel Custard

9
Cranberry Juice
Bacon, Toast
•
Washington Chowder
Individual Chicken Pie
Baked Potato With Herb Butter
Buttered Asparagus Tips
Spiced Peach Salad
Neopolitan Ice Cream
•
Frankfurters on Buns
Baked Beans
Cabbage and Carrot Salad
Gingerbread With Orange Topping

10
Applesauce
Plain Omelet
•
Cream of Corn Soup
Fried Soft Shell Crabs
Delmonico Potatoes
Frozen Spinach With Lemon
Stuffed Celery
Apricot Halves
Chocolate Brownies
•
Tomato Barley Soup
Half Tuna Sandwich
Half Swiss Cheese Sandwich
Stuffed Egg Salad
Pineapple Upside-Down Cake

11
Pear Nectar
Sausage Patties
•
Consommé Princess
Swiss Steak
Rice With Gravy
Mustard Greens
Cornbread
Beet and Onion Salad
Lemon Sponge Pudding
•
Broiled Chicken Livers
Hashed Brown Potatoes
Buttered Peas
Frosted Grape Salad
Coconut Pie

12
Tangerines
Scrambled Eggs With Ham
•
Oyster Cocktail
Roast Turkey
Giblet Dressing With Gravy
Broccoli, Hollandaise Sauce
Brandied Peach Salad
Pumpkin Pie With Whipped Cream
•
Hamburgers on Buns
Potato Salad
Pickle Relish
Sliced Tomatoes
Pecan Crunch Ice Cream

13
Prune Juice
Poached Egg on Toast
•
Cream of Lima Bean Soup
Roast Pork Loin
Sweet Potato Tiers
Stewed Turnips
Radish Roses, Carrot Curls
Baked Apples Stuffed With Raisins and Nuts
•
Barbecued Beef Cubes
Oven-Browned Potatoes
Whole Green Beans
Head Lettuce With Thousand Island Dressing
Cranberry Spice Cake

14
Sliced Oranges
Bacon and Egg Ring
•
Vegetable Soup
Veal Birds
Escalloped Spaghetti
Crowder Peas
Corn Sticks
Green Goddess Salad
Maple Nut Pudding
•
Chicken à la King in Patty Shells
Snowflake Potatoes
Buttered Asparagus
Pineapple and Grated Cheese Salad
Chocolate Eclairs

15
Apple-Lime Juice
Waffles With Sirup
•
French Oyster Soup
Fried Shrimp
Stuffed Baked Potatoes
Frozen Mixed Vegetables
Snowball Salad
Lemon Meringue Pie
•
Crabmeat Mornay
Chambery Potatoes
Fried Eggplant
Poinsettia Salad
Strawberry Sundae

16
Stewed Rhubarb
Link Sausages
•
Split Pea Soup
Meat Loaf With Tomato Sauce
Buttered Rice
Cauliflower Rochel
Orange and Grapefruit Section Salad
Cheese Cake
•
Broiled Steak
Shoestring Potatoes
Squash en Casserole
Wilted Spinach Salad
Fruit Cocktail
Oatmeal Cookies

17
Blended Fruit Juice
Fried Eggs
•
Minted Fruit Cup
Broiled Pompano
Maître d'Hôtel Potatoes
Brussels Sprouts
Cloverleaf Rolls
Marinated Green Bean Salad
Pistachio Ice Cream
•
Sautéed Scallops
Potatoes O'Brien
Green Peas With Mushrooms
Shamrock Salad
Pears In Lime Gelatin

18
Stewed Apricots
Canadian Bacon
•
Mulligatawny Soup
Broiled Lamb Chops
Clemenceau Potatoes
Cabbage With Cheese Sauce
Mixed Vegetable Salad
Sliced Pineapple
Peanut Butter Cookies
•
French Onion Soup
Meat Turnovers
Frozen Fruit Salad
Boston Cream Pie

19
Grape Juice
Shirred Eggs
•
Consommé Julienne
Baked Ham, Raisin Sauce
Candied Yams
Buttered Green Limas
Poppyseed Rolls
Princess Salad
Banana Split
•
Chicken Salad
Shoestring Potatoes
Hearts of Artichoke Salad
Strawberry Schaum Torte

20
Frozen Strawberries
Bacon
•
Scotch Broth
Stuffed Beef Patties
Noodles in Brown Gravy
Baked Onion Rings
Lazy Daisy Salad
Black Bottom Pie
•
Pork Chops Supreme
Buttered Potato Cubes
Creamed Corn
Lettuce and Egg Salad
Heavenly Hash

21
Tangerine Juice
Coddled Eggs
•
Chicken Gumbo
Roast Veal
Spanish Rice
Buttered Wax Beans
Stuffed Date Salad
Black Walnut Ice Cream
•
Brunswick Stew
Combination Salad
French Rolls
Apricot Crisp

22
Fresh Pears
Cheese Omelet
•
Shrimp Cocktail
Trout Marguery
Soufflèed Potatoes
Asparagus With Hollandaise Sauce
Stuffed Nectarine Salad
Caramel Cake
•
Cream of Vegetable Soup
Deviled Eggs
Sardines
Adirondack Salad
Peach Halves
Coconut Macaroons

23
V-8 Juice
Broiled Ham
•
Duchess Soup
Roast Long Island Duck
With Broiled Oranges
Wild Rice Stuffing
Mashed Turnips
Spiced Crabapple Salad
Pecan Tarts
•
Tamale Stuffed Peppers
Duchess Potato Puffs
Buttered Broccoli
Head Lettuce With French Dressing
Lime Sherbet

24
Half Grapefruit
Waffles With Honey Butter
•
Cream of Tomato Soup
Deviled Crab
Lattice Potatoes
Frozen Mixed Vegetables
Endive Salad
Banana Cream Cake
•
Broiled Halibut Steak
Macaroni With Tomato and Cheese Sauce
Eggplant Puffs
Stuffed Fig Salad
Lemon Snow Pudding With Custard Sauce

25
Peach Nectar
Scrambled Eggs
•
Chicken-Rice Soup
Baked Pork Steak
Corn Pudding
Buttered Green Beans
Tomato and Avocado Salad
Apple Pie With Cheese
•
Tenderloin Tips on Toast
Lyonnaise Potatoes
Buttered Baby Beets
Butterfly Salad
Bread Pudding With Hard Sauce

26
Honeydew Melon
Pancakes With Sirup
•
Crabmeat Cocktail
Broiled Chicken, Wine Mushroom Sauce
Persillade Potatoes
Buttered Whole Carrots
Apricot Salad
White Almond Cake, Coconut Frosting
•
Beef-Noodle Soup
Cold Cuts
Potato Salad
Assorted Relishes
Peppermint Ice Cream With Chocolate Sauce

27
Pineapple Juice
Bacon and Egg Rings
•
Cream of Potato Soup
Stuffed Lamb Shoulder
Baked Sweet Potatoes
Buttered English Peas
Spiced Pear Salad
Chocolate Cream Pie
•
City Chicken Legs
Princess Potatoes
Buttered Brussels Sprouts
Asparagus Salad With Piquante Dressing
Fruited Tapioca Pudding With Whipped Cream

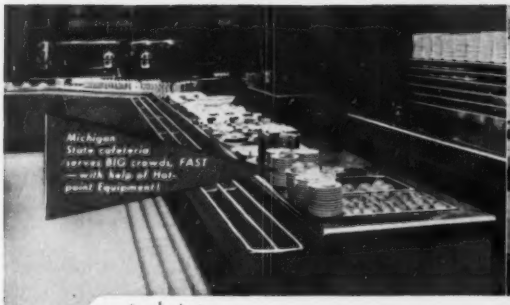
28
Kadota Figs
Fried Eggs, Rolls
•
English Beef Broth
Broiled Ham
Buttered Grits
Black-Eyed Peas
Corn Muffins
Cucumber and Onion Salad
Apple Goody Pudding
•
Meat Balls and Spaghetti
Mixed Green Salad With Garlic Dressing
French Bread
Ambrosia
Cookies

29
Loganberry Juice
French Toast, Jelly
•
Turtle Soup
Broiled Spanish Mackerel
Escalloped Potatoes
Fresh Frozen Spinach
Head Lettuce, Pimiento Cheese Dressing
Fresh Peach Ice Cream
•
Cream of Mushroom Soup
Avocado Stuffed With Shrimp Salad
Potato Chips
Olives and Pickles
Angel Pie

30
Dried Fruit Compote
Sausage Patties
•
Chicken-Noodle Soup
Filet Mignon
French Fried Onions
Baked Squash
Tomato Flower Salad
Pear Halves
Ginger Cream Cookies
•
Minestrone
Roast Pork Sandwich
Apple Rose Salad
Devil's Food

31 Fresh Orange Juice, Poached Egg • Tomato Juice Cocktail, Lobster Thermidor, Potatoes Parisienne, Harvard Beets, Jellied Fruit Salad, Eggnog Pie With Brazil Nut Crust • Individual Tuna Pie, Corn on the Cob, Cranberry Nut Salad, Vanilla Ice Cream With Fudge Sauce.

Ready-to-eat or cooked cereals are offered on all breakfast menus.



"Big Appetites vs. Slim Pocketbooks"

ALL-ELECTRIC COOKING WINS!

. . . AT MICHIGAN STATE

East Lansing, Michigan

"Huge healthy college appetites (and always in a hurry) but thin collegiate pocketbooks" . . . that's the *problem* at Michigan State. A Hotpoint All-Electric Kitchen is an *important* part of the answer.

AND it's so *good* an answer, the Kitchen also is one of the four Hotpoint-equipped Grand Award Winners in Institutions Magazine's 3rd Annual Food Service Competition.

At Michigan State many young people are eating their first away-from-home meals and comparing them with Mother's cooking. Here again All-Electric Equipment takes highest honors. The food is *good*, the service is fast, the cafeteria is clean and pleasant. The prices are very reasonable—and All-Electric Cooking is a big factor in keeping those prices *down* within reach of the students' slender budgets.

4 OUT OF 5 GRAND AWARD WINNERS IN 1949 FOOD SERVICE COMPETITION HAVE HOTPOINT ALL-ELECTRIC COOKING EQUIPMENT

A Grand Award Winner

IN INSTITUTION'S MAGAZINE'S 3rd ANNUAL FOOD SERVICE CONTEST

*Hotpoint All-Electric Kitchens

You, too, can benefit from the advantages of All-Electric Cooking! Your labor costs will be *lower*, your maintenance *easier*, your turnover *faster*, your food *better tasting* . . . AND YOUR PROFITS WILL BE HIGHER.

Remember—in your operation, LOWER COSTS mean INCREASED PROFITS. Your nearest Hotpoint Representative will be glad to talk it over with you whether you have immediate plans for building or remodeling or are looking to the future—see your Hotpoint man soon!

***You can profit* from the experience of these and countless other leading food establishments by using All-Electric Cooking in your own operation. Your Hotpoint Representative is at your service. Let him give you the facts about increased efficiency, lower costs, greater safety and better cooking with Hotpoint.**

HOTPOINT INC.* Commercial Cooking Equipment Dept.

ALL-ELECTRIC COOKING

with Hotpoint

***A General Electric Affiliate**

MAIL COUPON for QUICK REPLY

HOTPOINT INC.,
Commercial Cooking Equipment Dept.
229 S. Seeley Ave., Chicago 12, Illinois

O. K.—Show us how we can increase our profits.

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BUSINESS_____

ADDRESS_____

CITY_____ STATE_____

SPECIALIZED UNIT FILLS A PRESSING NEED

in finishing hospital wearing apparel

FRITZ FIELD
Laundry Manager, Beth Israel Hospital, New York City

OUR entire progress toward a healthier and better standard of living has gone hand in hand with specialization of operations. Manufacturing operations have been broken down into specialized units. There is specialization in many other activities; even doctors specialize in a certain field to become more expert and more active in it.

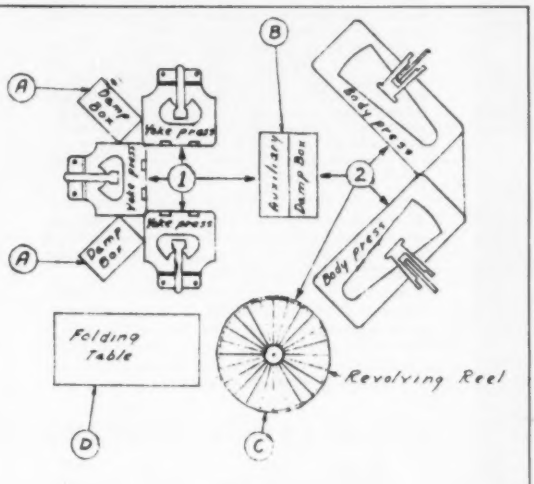
Specialization in finishing operations of wearing apparel was introduced about 10 years ago and, because of the variety and complexity of the garments to be processed, has led to vast improvements in quality and production. With wage rate levels rising and the supply of experienced personnel decreasing, it was particularly desirable to provide means for finishing wearing apparel so that unskilled labor could be taken into the pressing department and trained quickly, and so that, as nearly as possible, the operators couldn't help but produce a quality garment.

This meant breaking down the whole finishing operation into component groups with the result that any one operator had only a few operations to learn; it meant developing the right finishing tools (presses, puffers and so forth) for the job and still keeping the required investment low, and it meant balancing the operations in a multiple operator unit so that the work was divided evenly and production could be high.

This was done first for the wearing apparel departments of laundries, then for the linen supply trade. Today it has been adapted for the hospital laundry.

Although wearing apparel is only about 7 per cent of the whole laundry volume processed, the appearance of the members of the staff is affected by the quality of their laundered garments. Proper finishing of these garments demands a high degree of skill.

These wearing apparel items and their daily flow into the hospital laundry were studied. It was found that the principal item is the nurse's uniform. There is so much variety in style, material and size in these uniforms that the finishing process has



A. – Damp Boxes. Two are provided at the pony presses to make the garments readily accessible to the press operator.

B. – Between stations the garments rest in an auxiliary damp box to facilitate the transfer of partly finished garments from operator ONE to Operator Two. This box is convenient to both operators.

C. – Finished garments are hung on a revolving reel. This facilitates inspecting and counting.

D. – Note folding table of sufficient size for the garments that are to be folded. This table can be eliminated where nurses uniforms are delivered on hangers.

LAYOUT OF PRESSES, DAMP BOXES AND FINISHED WORK RACK.

"SLYDE-OUT" WASHER IN ACTION — Cylinder stops with load on waist-high partition — operator slides load into basket with an easy scoop of arm. No stooping — no lifting — no backbreaking effort!
Photo courtesy ST. ANTHONY'S HOSPITAL, CARROLL, IOWA.

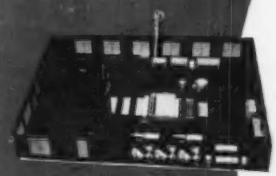
Another view of [illegible] HOSPITAL, showing Troy Drying Tumbler and Troy Flatwork Ironer.

To Lower Laundry Costs
Another Hospital Installs

TROY "*Slyde-Out*" WASHERS

Hundreds of hospitals are speeding up production and reducing labor costs with Troy Electromatic "Slyde-Out" Washers. These modern washers eliminate unloading drudgery for employees and produce sparkling clean linens in less time than ever before. Easy to operate — just set dial, add supplies and Electromatic Washer control does the rest automatically. Low maintenance costs.

Corrosion-proof, stainless steel constructed throughout, "Slyde-Out" Washers are built in four sizes: 42" x 36", 42" x 54", 42" x 84", 42" x 96". Models with manual controls also available.



"Photo Plan"
SERVICE

Troy laundry engineers study your needs and plan most efficient layout. Scale models of laundry machines are set up on a miniature of your floor plan, then photographed and an easy-to-read three-dimensional photograph is furnished to you. No charge for this Troy service. Write for details.

***WRITE FOR FREE CATALOG** complete with illustrations, specifications and operating details.*

ELECTROMATIC "*Slyde-Out*" WASHERS

MANUFACTURED EXCLUSIVELY BY

TROY LAUNDRY MACHINERY

Division of AMERICAN MACHINE AND METALS, INC., EAST MOLINE, ILLINOIS

In Canada: American Machine and Metals (Canada) Ltd., 1144 Weston Road, Toronto 9, Ontario

COMPLETE LINE OF LAUNDRY AND DRYCLEANING EQUIPMENT

always presented a difficult problem. As a result, a unit was developed at Beth Israel Hospital, New York, for finishing such uniforms with high quality and high production and at low cost.

This unit, which is also extremely useful for all items of wearing apparel, is a two-operator process consisting of three small presses and two large tapered presses. The sketch shows the arrangement of the presses and the locations of the damp boxes and finished work rack.

For uniforms, Operator No. 1 uses the three small presses which are designed to fit into and press properly all parts of the garment above the waist. These presses are arranged to require the least movement and effort on the part of the operator. Operator No. 2 uses the two tapered 51 inch presses which are designed to press properly the skirts of the uniforms in the least number of lays. This operator presses the skirts of the uniforms and the long sleeves. These two presses are also arranged to permit making lays quickly and easily while requiring a minimum of movement on the part of the operator.

From this unit two operators have averaged up to 24 good quality, completely pressed uniforms per hour. Most of these uniforms have long sleeves and are fitted types with waistbands. On these uniforms, no hand finishing is required.

The unit has flexibility and may be used as a general utility unit with one or two operators for finishing other items of wearing apparel.

As a two-operator unit, it does a beautiful job on dress shirts and doctors' shirts. One operator with the two large tapered presses makes the best possible unit for finishing nurses' aprons. One operator uses the three small presses as a unit to finish underwear and other small pieces. Two operators use the small and large presses as a unit to finish trousers and coats. On each of these classes of garments the production is as great as from any other type of utility unit.

WHY IT WORKS SO WELL

One may rightly ask why this arrangement of the unit is better for the finishing of uniforms than any other. Here are some of the reasons:

1. Quality garments are obtained by introducing into the unit press shapes which fit the garments to be pressed. High production is obtained by having the correct grouping of these presses to permit specialized operation, and through shaping the press bucks to permit easy rapid laying of the garments.

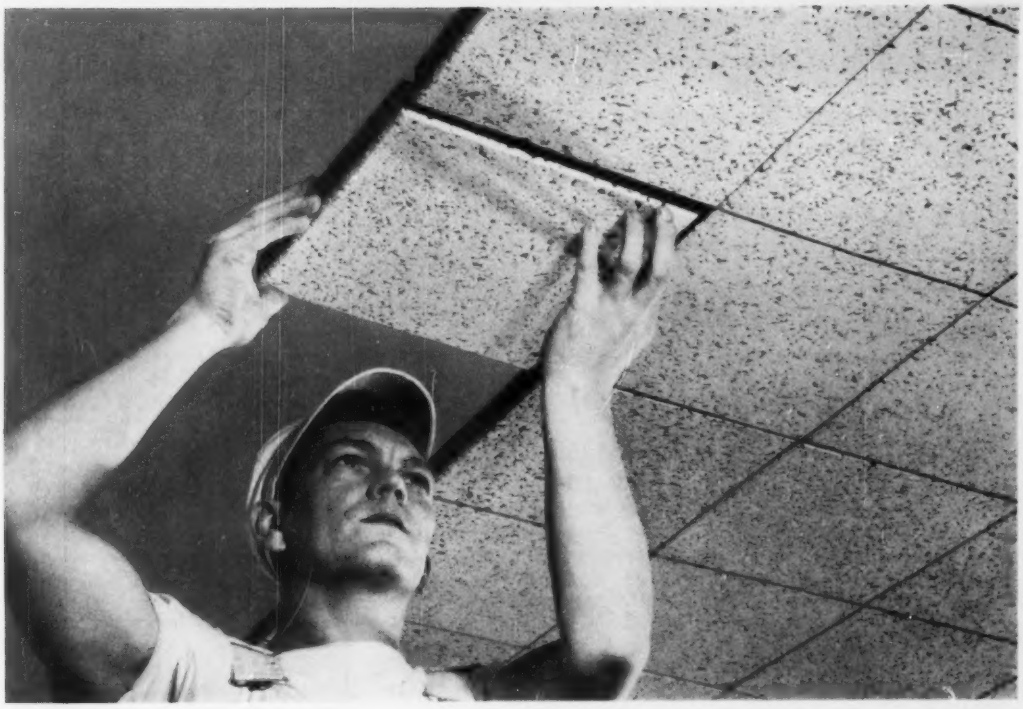
2. Each of the two operators has to learn to do only a certain part of the uniform. Therefore, training time is reduced to a minimum.

3. When an operator repeatedly does only a few simple operations rather than many, these operations become easy and the average person can develop a greater speed and skill on a few operations than she can on several operations. Thus the operator is able to give greater production and quality on the parts of the garment on which she concentrates.

4. Because the operations are broken down and divided among operators, it is unnecessary to hire and pay for highly skilled personnel.

5. The operator increases her productive capacity.

6. The shapes of the presses, and particularly of the small presses, are such that every square inch of the uniform can be beautifully finished on the presses and no touch up is required.



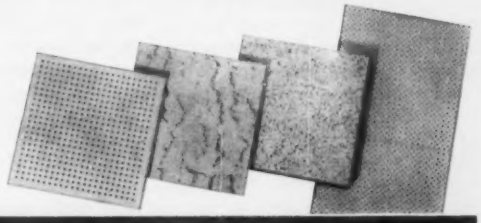
Quiet for high-humidity hospital areas

HOSPITAL areas which are subject to excessive moisture present an acoustical problem of a special nature. Ceilings of Armstrong's Corkoustic provide the ideal solution. In hospital kitchens and hydrotherapy rooms, Corkoustic reduces noise and is unaffected by moisture conditions. Its low-density cork structure gives it high natural resistance to such moisture, thus preventing undue swelling and warping of the ceiling tiles.

Corkoustic ceilings can be used to advantage elsewhere in the hospital, too. In the lobby, auditorium, and administrative offices, its white, fissured surface adds distinctive decoration to the ceiling. This surface affords excellent light reflection, without glare, and can be repainted without noticeable loss of acoustical efficiency. Corkoustic has high thermal insulation value as well—an important consideration in hospitals of single-story construction.

Armstrong's Corkoustic is quickly and economically installed. Being unusually light in weight, it can be applied simply by cementing the tiles to the existing plaster ceiling.

There's an Armstrong acoustical material to meet every kind of sound-conditioning requirement. Get full details from your Armstrong acoustical contractor or write to Armstrong Cork Company, 5702 Stevens St., Lancaster, Pennsylvania.



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ARMSTRONG'S ACOUSTICAL MATERIALS

CUSHIONTONE* TRAVERTONE* CORKOUSTIC* ARRESTONE*

Conducted by Alta M. La Belle and Jane Barton

Boston University presents—

THE BENEFITS OF ACCIDENT PREVENTION

ROBERT CLAIR
Director of Safety Education
Loss Prevention Department, Liberty Mutual Insurance Company

IT is generally acknowledged that effective accident prevention is good business and that a favorable no-accident record goes hand in hand with efficient management, supervision and workmanship. This statement is significant because all of us are seeking improved and more economical methods for carrying out our everyday responsibilities.

Beyond this fundamental fact, effective accident prevention protects our employes and enables them to remain at work in good physical condition; it promotes the desire on the part of our employes to remain with our institution; it prevents property damage; it influences the cost of workmen's compensation and public liability insurance, and it helps to build and maintain good public relations with our guests.

THESE ARE MOST IMPORTANT

We shall here discuss three of the more important of these benefits of successful accident prevention:

1. Influencing the cost of workmen's compensation and public liability insurance.
2. Assisting in improving the quality of housekeeping.
3. Helping to build and maintain good public relations.

We shall conclude by offering a few suggestions regarding some of the important things we can do for the more effective control of accidents in our housekeeping departments.

Before we consider the three benefits, let us be sure we understand that we *do* have the problem.

There are two kinds of accidents happening in institutional housekeeping departments:

First, there are accidents resulting in injuries to employes that are known as workmen's compensation accidents.

In July of 1947 the Hotel Association of New York City released the following accident analysis data based on reports from 87 hotels and covering the first five months of 1947:

Departments showing most days lost because of accidents: housekeeping 29.4 per cent; dining room, 17.2 per cent; kitchen, 16 per cent; engineering, 15.6 per cent; steward, 7.8 per cent; all others, 14 per cent.

Lost time accidents by departments: housekeeping, 27.7 per cent; kitchen, 21.7 per cent; dining room, 15.7 per cent; engineering, 13.4 per cent; steward, 7.4 per cent; all others, 14.1 per cent.

Types of lost time accidents: falls, 27.4 per cent; strains and sprains, 19.4 per cent; bumps and bruises, 19.4 per cent; cuts, 15.7 per cent (four types, 81.9 per cent of the trouble).

Types of accidents causing greatest loss of time: falls, 34.1 per cent; bumps and bruises, 20.4 per cent; strains, 20 per cent; cuts, 10.2 per cent (four types, 84.7 per cent of the trouble). These figures indicate very positively that housekeeping departments have a serious workmen's compensation accident prevention problem.

Second, there are injuries involving guests.

We have analyzed 463 guest accidents. Although we were not able to allocate these to the various departments, we found that the following were the leading types:

1. Slips and falls, 43 per cent.
2. Defective equipment, 10 per cent.

In other words, two types of guest injuries account for 53 per cent of the trouble.

We have many other interesting statistics. However, I assume you are already familiar with your own statistics and I should like to move along to a consideration of three major benefits of accident prevention. It is enough for us to state at the moment that we are having accidents, that these have definite causes and that, therefore, a real accident prevention problem exists in our housekeeping departments.

Accident Losses Influence the Cost of Insurance:

The management of every institution carries, among other types of insurance, workmen's compensation and public liability.

Workmen's compensation insurance premium rates are based on the accident loss experience in the particular type of business modified, in some cases, by individual loss experience.

For example, in 1936 the New York State workmen's compensation premium rate, per $100 of pay roll, was $1.91. The hotel industry inaugurated an aggressive accident prevention program. By 1940 the accident experience had so improved that a manual rate of $1.55 per $100 of pay roll was allowed. This 19 per cent reduction meant a saving of $335,000 to New York State hotels in 1940 alone.

Since then the manual rate has increased to $2.30 in 1946—an increase of 33 per cent from the $1.55 rate of 1940. This increase was largely due to wartime manpower shortages and high labor turnover.

Not only is the manual or basic workmen's compensation premium rate affected favorably or unfavorably by the general trend of accident loss experience in the hotel industry throughout the state, but individual houses may acquire additional credits or charges, in some cases, by their own accident loss experience being better or worse than average.

A comparison of workmen's compensation insurance premium rates for a group of association hotels, computed on 1946 manual rates and 1946 individual experience modifications, indicated a range from the lowest rate of $1.50 (a 35 per cent credit) to the highest rate of $3.47 (a 51 per cent charge). On this basis the annual cost of workmen's compensation insurance for an employe receiving $2000 a year in a $1.50 rate hotel would be $30; in a $2.30 (average) rate hotel, it would be $46, and for the $3.47 rate hotel, it would be $69.

The rate for public liability insurance, generally speaking, is also influenced by the accident loss experience of the industry.

Housekeepers are, therefore, in a position to exercise a considerable influence on these insurance premium rates, which the management of our houses pays, in proportion to the effectiveness of the accident prevention job which we do.

Accident Prevention Can Improve the Quality of Housekeeping:

There is really no such thing as "safety" that exists as a separate activity or entity in itself. It is a basic mistake to think that there is.

Many people still consider that accident prevention is "just another job," something additional to be done beyond regularly assigned duties, nonessential window trimming for which they cannot spend the time or effort. These people are usually not very effectual.

An outstanding no-accident record is merely one indication of an efficiently operated department or establishment; high quality and required quantity of work, meeting time schedules, and constant cost control are other indications of effective management.

The objective of all accident prevention work can be stated simply as follows: "Getting the maximum number of people to do the work assigned to them the right way." This, perhaps surprisingly, is not only the accident prevention objective but also a basic objective of all thoughtful, ambitious management in industry and business. This is because the right way is the most economical way, the easiest way, the smoothest way, and, incidentally, the safe way to do anything. In other words, the right way is the best way for our people to do their work.

What is the housekeeper's principal responsibility? I think everyone will agree that it is to maintain public spaces, guest rooms and corridors in accordance with the highest standards of order and cleanliness. With the personnel assigned to us, we must meet certain specifications of quantity, quality, cost and time of work done.

Many incidents may occur to interrupt or interfere with our compliance with these "highest standards of order and cleanliness." An accident is one of the most serious forms of interruption.

For instance, if we are depending on a maid to take care of a certain number of guest rooms and if she falls from the edge of a bathtub and injures her back, or if she gashes her hand badly on a razor blade while digging rubbish out of a wastebasket, we immediately have not only an accident but also a production problem on our hands. It is obvious that a series of such accidents can substantially disrupt our operating organization.

We must conclude, therefore, that we cannot ignore accidents inasmuch as they strike at the very heart of our principal responsibility. The successful housekeeping executive or supervisor needs and therefore must build accident prevention into the everyday work of her people. Accidents disrupt our regular operating functions and, depending on the seriousness of injuries, the effectiveness of our work is reduced proportionately. The more injuries there are, the more loss of efficiency there is.

We invariably find that the most capable operating departments are those that have the best no-accident records and it has been proved many times that an outstanding no-accident record is one of our greatest stepping stones toward greater responsibilities and promotion to higher positions. Successful accident prevention is therefore intimately associated with our personal success.

Accident Prevention Helps to Build and Maintain Good Public Relations:

In addition to the damage that employe accidents can inflict on the carrying out of our principal operating responsibilities, these same employe injuries also often damage the public relations of the institution.

Liberty Mutual has adopted the phrase "Smoothing the Flow of Hospitality" to describe perhaps this greatest benefit that an institution derives from an effective accident prevention program.

What Can We Do for More Effective Control of Accidents?

We have already said that the objective of all employe accident prevention work is to get the maximum number of people to do the work assigned to them the best way. If there is any magic formula, that is it.

Here are a few of the more important suggestions that we should put to work for us:

1. Remember that every accident has two parts—a cause and a result. Invariably an accident is caused because someone does something he should not have done (mistake or wrong method) or fails to do something he should have done (failure to act or to use proper method). Therefore, to prevent accidents, we must detect, anticipate and eliminate the unsafe acts or omissions that cause them.

2. Much is being done about selective placement. Be sure to assign the person with the qualifications necessary for each job.

3. Job analysis. We must study the requirements of each job. We must know its physical requirements and the sequence of manual methods it requires. In this respect it should not be necessary for anyone to remind us how wastebaskets should be emptied; how shower curtains should be hung; what the condition and use of our tools and equipment should be; that the use of furniture handles and door knobs prevents finger pinches; that our people should not run but walk; that they should always use their stair hand rails, and so forth.

Job analysis often results in job simplification which reduces the effort and time elements and incidentally fatigue and other accident hazards. We should be familiar with this common sense operating technic—one of the most interesting examples of which was described in one of the hotel trade journals. It is a bedmaking method that reduces a chambermaid's time and distance walked by about 55 per cent from the old conventional procedure. That certainly represents both smart job analysis and smart accident prevention.

4. Instruct new people by explaining to them in specific detail what they are to do, why they are to do it, and how they are to do it.

5. Demonstrate these best methods of performance.

6. Allow employes to practice best methods under supervision until they develop the required skill.

7. Constantly check and supervise employes to make sure they are doing their work as they were originally told to do it.

8. Retrain veteran employes, by means of refresher courses, in best methods.

9. Inspect the premises continuously to detect physical hazards and to make sure that the methods being used by our people actually meet the job specifications.

10. Follow up and follow through to make sure that all hazards found are corrected promptly.

So much for the prevention of employe injuries.

Although guests are injured in much the same manner as employes, the prevention of guest injuries presents some different aspects.

Injuries to employes result in losses under workmen's compensation insurance coverage. Injuries to guests cause public liability insurance losses.

In preventing injuries to employes we are dealing with people on the same pay rolls with us whom we are able to select, instruct, train and supervise in best methods. We have no such advantages in the prevention of injuries to guests. Our approach, therefore, to the control of public liability losses resulting from guest injuries may be briefly explained as follows:

We must exercise extraordinary care to detect and remove any condition that may cause an accident to a guest. Losses here follow legal liability, and legal liability refers to faults. It is my fault if I *do* something in connection with the housekeeping of my hotel which a housekeeper who knows her business would *not* do.

Conversely, it is also my fault if I do *not* do something, having to do with the operation of my hotel, which the average intelligent housekeeper *would* do. For instance, the day we come to work and fail to examine and correct conditions in any part of the areas assigned to us is an unprofitable day for us if a guest falls and breaks a leg as a result of a condition which an alert executive housekeeper would have discovered and corrected.

MUST REPORT HAZARDS

We must, therefore, instruct our personnel to foresee hazards and to report or eliminate them. Then if a guest should suffer injury as the result of an accident, no conditions exist (except good ones) for a court to decide upon as to negligence.

For instance, many guest injuries occur in their rooms and can be prevented if the chambermaids check the rooms thoroughly for hazardous conditions before leaving them. Most of us require our maids to fill out forms listing articles found, damaged or missing. We should consider adding to these same forms a simple accident hazard check list.

In the final analysis, the housekeeping public liability problem resolves itself into a matter of eliminating any and all conditions which exist through negligence on the part of the institution or its employes.

This problem will be largely solved if we effectively perform our first responsibility of maintaining public spaces, guest rooms and corridors in accordance with "the highest standards of order and cleanliness."

NEWS DIGEST

May Be Surplus of Physicians by 1960, A.M.A. Says . . . Bethlehem Steel Enrolls in Blue Cross . . . Bellevue Opens New Type of Clinic . . . Nursing Group Fights Interim Classification . . . A.C.S. Approves 3284 Hospitals

There May Be Surplus, Not Shortage of Physicians by 1960, A.M.A. Journal Says

CHICAGO. — Challenging a recent report issued by the Federal Security Agency, the *Journal of the American Medical Association* said last month it was possible there would be a surplus of physicians in the United States by 1960. The F.S.A. had estimated a shortage of physicians would develop.

"It is difficult to forecast the national demand for physicians," the *Journal* stated, "because it is practically impossible to estimate in advance the rapidity of technologic progress in the practice of medicine. During the 1940's a great increase in the number of auxiliary personnel as well as improvements in therapeutic remedies greatly enhanced the amount of medical service physicians could render. The Bureau of Medical Economic Research has estimated that the increase in productivity per physician during the 1940's might have been as much as one-third. If this trend continues, it certainly seems more reasonable to expect a surplus than a deficit of physicians in 1960."

On the same subject, Dean Willard Rappleye of Columbia University's College of Physicians and Surgeons stated in his annual report that the need is for "better, rather than more doctors." Additional financial resources must be obtained by medical schools, Dean Rappleye said, to maintain and improve existing standards of training rather than to expand facilities. Dean Rappleye urged federal and state subsidies for medical schools, private fund raising and use of the earning power of clinical staffs to increase revenue.

Meeting at Cincinnati last month, the American Conference of Academic Deans charged medical schools and the medical profession with restrictive policies resulting in the denial of professional educational opportunity to many qualified students. A conference committee on preprofessional education recommended standardization of medical school admission requirements and a sharp increase in the number of students admitted to medical schools.

Lehigh Valley Blue Cross Enrolls Bethlehem Steel Under Five-Year Contract

BETHLEHEM, PA. — Some 400,000 workers of the Bethlehem Steel Company have been enrolled on a nationwide basis by the Hospital Service Plan of Lehigh Valley under a five-year contract. The annual premiums will amount to more than $4,000,000 a year.

According to E. A. vanSteenwyk, who helped negotiate the contract, the decision was made by Bethlehem Steel largely because it wished to be identified with local forces for health. In the negotiations, big business, the labor unions, and local health facilities all were involved.

The uniform rate structure permits the insured 70 days per illness and semiprivate accommodations.

Bellevue Hospital Opens New Type of Clinic for Ambulatory Patients

NEW YORK.--A new type of clinic for ambulatory patients at Bellevue Hospital providing comprehensive diagnostic and general medical care to the indigent sick was opened here last month by Dr. Marcus D. Kogel, commissioner of hospitals; Dr. William F. Jacobs, medical superintendent of Bellevue, and Dr. Robert Boggs, dean of the New York University Postgraduate Medical School.

Staffed by 250 physicians and surgeons who are members of the faculty of the medical school of New York University-Bellevue Medical Center, the new clinic features the fact that its patients will have appointments with their doctors and will be seen in private; that the clinic's staff will comprise a complete medical and surgical team, including senior surgeons, physicians and other specialists from the school's faculty, and that when in full operation, the clinic will be open all day, five days a week.

Located on the fifth floor of Bellevue's outpatient department building, the clinic includes some 67 examination rooms, laboratories and small operating rooms, all of which have been newly decorated and reequipped.

Repeal Federal Taxes on Oleomargarine

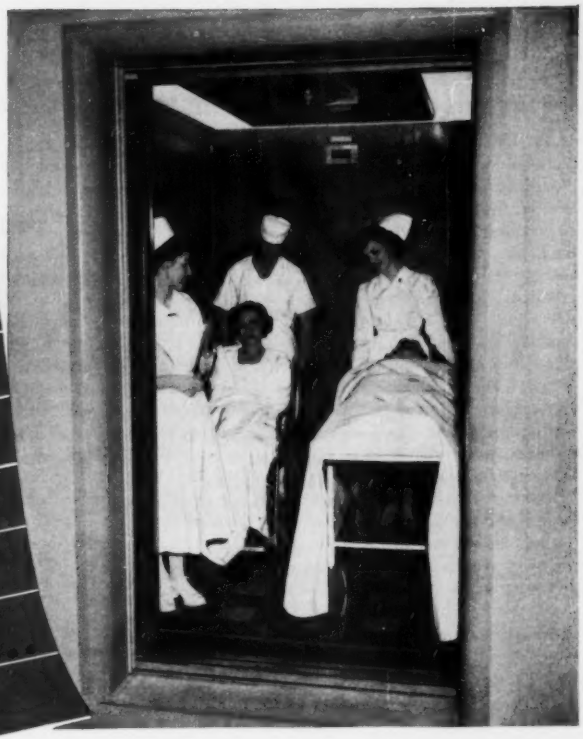
WASHINGTON, D.C.—Federal taxes on oleomargarine were eliminated when the Senate passed the bitterly contested repeal bill January 18. A similar bill was passed by the House in the first session of the 81st Congress.

The bill was scheduled to go to a joint conference committee last month; it was expected that President Truman would sign it as soon as the committee ironed out differences between the Senate and House versions of the bill.

Under the new measure, the 10-cents-a-pound federal tax on colored margarine and the ¼ cent tax on white margarine would be eliminated, as would special handling and license fees.

Opponents of the bill succeeded in obtaining amendments requiring restaurants serving oleo to identify it and requiring retailers to serve oleo in triangular molds.

CHRIST HOSPITAL, *Jersey City, will open a new wing this month. This will bring the total capacity of the hospital to 355 beds plus 65 bassinets. Four Westinghouse hospital elevators, each with a 4,000 lb. capacity, provide swift, sure vertical transportation.*



CHRIST HOSPITAL

JERSEY CITY

Your hospital can have an elevator system that has been specially engineered to fill the exacting requirements of a hospital: deep cars, rubber isolated cars, wide doors, ample ventilation, easily cleaned floors and walls and indirect lighting. Plus, the qualities common to all Westinghouse Elevators — fast, smooth, silent and safe operation.

Westinghouse has had years of practice at building **hospital** elevators — not just elevators. Elevators that are the right size and shape to accommodate a hospital's unusual equipment as well as patients. Elevators that through the years have been refined to fill a hospital's distinctive demands.

Send for our booklet "Hospital Highways," and read the story behind the development of better hospital elevator service. You'll see why hospitals that want the best elevator service come to Westinghouse.

YOU CAN BE SURE...IF IT'S Westinghouse

J-98566

NEWS...

New Group Will Combat Legislation Unfavorable to "Unclassified" Nursing Schools

ATLANTA, GA.—Formation of the National Organization of Hospital Schools of Nursing, Inc., was announced here last month by Lucy I. Mace, secretary-treasurer of the organization; H. Louie Wilson, administrator of the Alachua Hospital, Gainesville, Fla., is president, the announcement said.

Purpose of the organization is to combat legislation regarded as unfavorable to hospital nursing schools not connected with colleges or universities, it was explained. Initial publicity distributed by the school organization referred to the interim classification survey of nursing schools as "damaging and disheartening" to schools not appearing on the classification lists.

"It is known that many good schools of nursing which have served their communities well do not appear on the list," the organization statement said. "The classification was based on a survey questionnaire. The schools were not advised that the information gained in the survey would be used in any way to disqualify their schools. No visits to schools have been made.

"The schools which do happen to appear on the list could not possibly expand their facilities to absorb the students of the schools which do not appear on the published list. Many hospitals are considering closing their schools of nursing because the present demands made upon them make it prohibitive to operate a school. In the first place qualified teaching personnel is not to be found in the land at any price to carry out the proposed program adequately.

"We believe that our present schools are needed and should continue. The three-year program might ultimately be shortened but this will require study and experiment.

"It is not the purpose of this organization to lower the standards of nursing education but to at least hold the progress that has been made and to work with the state boards of nurse examiners to improve our hospital schools of nursing and to move safely and soundly towards achieving better nursing care for the American people."

The organization charged that the National Committee for the Improvement of Nursing Service, the U.S. Public Health Service and the American Hospital Association "apparently advocated the disappearance of hospital schools as they are now known and advocate untried and unproven programs."

Objectives of the National Organization of Hospital Schools of Nursing were named as follows: "to promote general education of nurses; to establish and assist in the operation of hospital schools of nursing; to broaden and elevate the art and science of nursing and the curricula of hospital nursing schools; to extend and improve hospital schools of nursing and nursing education; to formulate plans, rules, regulations and programs for the use of hospital schools of nursing; to safeguard the status of graduate nurses in the practice of their profession; to prepare and assist hospitals in obtaining a better supply of better trained help over the nation."

Negro Surgeon Dies at Staff Meeting After Speech Urging Support of Hospital

CHICAGO.—On Sunday morning, January 15, the attending staff of Provident Hospital here called its membership together for a 9:30 breakfast meeting for the purpose of discussing its contributions to the Provident Hospital fund-raising campaign. About 70 per cent of the total attending staff turned out to hear the discussion and ended by subscribing almost $10,000 to the fund.

One of the featured speakers was Dr. Carl Roberts, formerly head of the department of surgery at Provident, who had retired several years ago because of a heart attack. He was a diplomate of the American Board of Surgeons, a fellow of the American College of Surgeons and one of the most respected and revered men in the community. In addition, he was nationally known among both Negro and white physicians for his great contributions to surgery.

Dr. Roberts attended the meeting against the advice of his physician to talk to his former colleagues about their obligations to support Provident Hospital. He gave a ten-minute talk on the subject and within five minutes of the time he sat down, he dropped dead.

In paying tribute to Dr. Roberts, leaders in the hospital field pointed out: "Here was a man who like a good warrior preferred to die with his boots on, battling for what he thought was a just cause."

Chicago and St. Louis Plans Enter Interim Agreement Until Dispute Is Settled

ST. LOUIS.—Group Hospital Service here and Plan for Hospital Care, Chicago, have agreed to discontinue the solicitation of memberships in a disputed area in southern Illinois in which both plans have been operating for the last year pending arbitration of the difficulties arising in the disputed territory, it was reported here last month. An arbitration group including representatives of the two plans and the Blue Cross commission conducted hearings in the dispute but has not yet rendered a final decision, it was explained.

The two Blue Cross plans last month entered into an interim agreement, the terms of which included dismissal of a suit brought by the St. Louis Blue Cross against five hospitals in the disputed territory, hospital membership in both plans and cessation of subscription solicitations until the dispute is settled.

Meanwhile, Group Hospital Service announced an increase in the membership on its board of trustees to provide greater hospital representation. New trustees elected by the board to serve until the annual meeting in June are: Adeline Geiger, Latham Sanitarium, California, Mo.; Dr. S. H. Frazier, Rosiclare Hospital, Rosiclare, Ill.; W. W. Martin, Masonic Home, St. Louis; Dr. Maynard W. Martin, St. Luke's Hospital, St. Louis, and Rev. E. C. Hofius, Lutheran Hospital, St. Louis.

Hospitals named in the suit which was dismissed last month when the interim arrangement was agreed upon were: Christian Welfare Hospital of East St. Louis; St. Mary's Hospital, Centralia; Herrin Hospital; St. Joseph's Hospital, Breese, and St. Mary's Hospital, East St. Louis.

Notice to Subscribers

Because of new postal regulations, it will be necessary to notify The Modern Hospital Publishing Company, 919 North Michigan Avenue, Chicago 11, promptly in case of change of address. The local post office should also be notified of anticipated change of address. Under new postal regulations subscribers may miss copies that will be impossible to replace unless this is done. Previous postal regulations provided for notification to the publisher by the post office so that it was not necessary for the subscriber to notify the publisher directly.

ideas from PROMINENT FOOD SERVICE INSTALLATIONS

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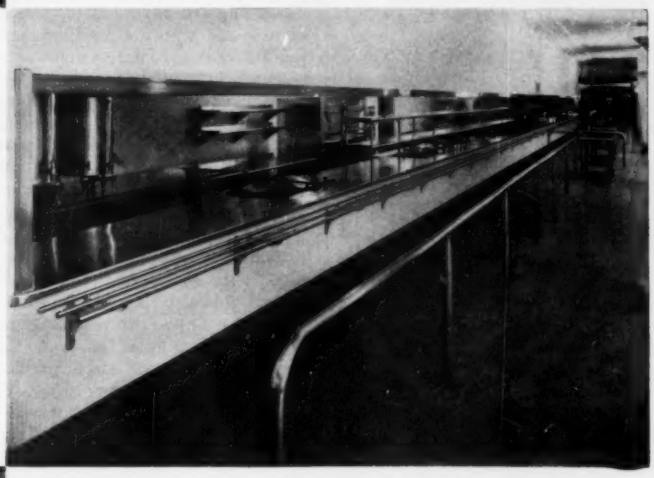
FOR SIMPLIFIED CLEANING—Round corner stainless steel pantry sinks and table. Note the manner in which sinks are attached to wall by means of stainless steel brackets. This eliminates leg obstructions, speeds cleaning. Open space is left between sink and wall for easy access for cleaning.

DURABLE STAINLESS STEEL CONSTRUCTION—View of stainless steel cafeteria counter and back bar equipment. Fully-welded construction. Counter tops are sound-deadened. Guard rails and supports have welded joints, with large radius fillets ground smooth and polished. Cleaning is quick and easy.

WASTE MOTION ELIMINATED—Movable shelf units are placed underneath work counter. These replace the customary fixed shelving. Dishes or other supplies are loaded on them and wheeled directly to serving counter, saving time and labor in re-handling.



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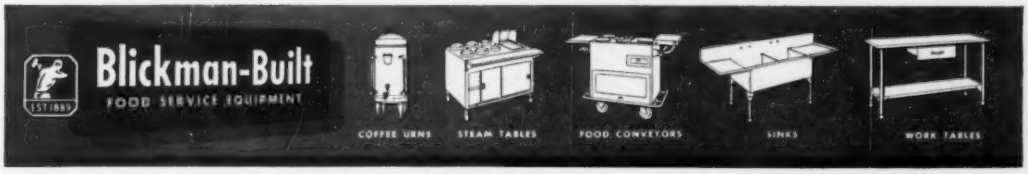


NEWS...

N. Y. Council Report Urges Addition of More Physicians to Staffs of Hospitals

NEW YORK.—Of the 17,700 physicians in this city, approximately 15,000 are engaged in the practice of medicine, and approximately 12,300 physicians have some type of hospital appointment, while 2700 practicing physicians have none, according to the annual report of the Hospital Council of Greater New York. The report was published here last month. Thus it would seem that a large segment of the population of 8,000,000 people is relying for its care on physicians with no hospital affiliation, the council report pointed out.

"The level of medical practice within any community depends primarily upon the association of its physicians with hospitals," the report stated. "The addition of more physicians to the staffs of hospitals, with the resultant opportunities for their education, training and guidance, is therefore to be regarded as a call upon the conscience of our hospitals' governing boards. As community institutions, hospitals have an interest in the quality of medical service available for the entire community, as well as that offered within their own walls.

"To integrate more physicians into the staffs of hospitals is not a simple task. It should, however, be faced and studied. Many of the physicians who do not have appointments are general practitioners. Only a few New York hospitals have thus far established places for the general practitioner as such. Until more opportunities are opened in many more hospitals, it will be difficult to absorb the major portion of the physicians who do not now have staff affiliations."

Referring to the council's study of the Emergency Ambulance Service of New York, the report indicated that only 45 voluntary and municipal hospitals provide an ambulance service. They operate 106 ambulances. As the system is now operated, there is divided responsibility among the hospitals and the police department, it was pointed out. "Full responsibility and authority might perhaps be better vested in one organization which could provide the whole service," it was suggested.

"It is not generally appreciated that many important hospitals do not run an ambulance service. The fact that only a limited number of hospitals provide such a service places a heavier burden on these institutions than would be the case if patients could be taken by an ambulance directly to the nearest hospital," it was explained.

Start 14 Story Addition at U. of I. Research Hospitals

CHICAGO.—Construction of a 14 story addition to the University of Illinois Research and Educational Hospitals was undertaken here last month, the university announced. Construction contracts total $5,368,628.

It is expected that the building will be enclosed within a year and general work will be completed within 18 months, it was explained.

Architect's drawing of 14 story addition to U. of I. Research and Educational Hospitals.

Start of work on the addition to the university hospitals will raise the amount of present construction in the West Side Medical Center District to more than $25,000,000, it was reported. Other projects now under construction are a Veterans Administration hospital, the Chicago State Tuberculosis Hospital, Cook County interns' residence, and the nurses' residence at Presbyterian Hospital.

Starts Hospital Benefits

SACRAMENTO, CALIF.—The state of California began paying hospitalization benefits to unemployed workers eligible for state unemployment insurance under the law passed last year. Payment is being made through 16 district offices throughout the state, it was explained at the unemployment insurance department here. The plan calls for payments of $8 a day up to 12 days' hospitalization for persons eligible to receive state unemployment insurance. It is estimated that the plan will cost approximately $8,000,000 a year.

NEWS...

Bureau of Census Plans Method of Enumerating Hospital Patients

WASHINGTON, D.C. — Enumeration of patients in general hospitals presents a problem that will receive special attention in taking the 17th Decennial Population Census next April, according to Philip M. Hauser, acting director of the Bureau of the Census. Superintendents of general hospitals and their staffs have been assured that the count will be carried out in hospitals with a minimum of distraction from routine operations, the director said.

Resident staff personnel are to be enumerated on the regular population schedules by enumerators employed by the bureau. Plans for obtaining answers to questions from patients provide that those who are able shall fill out individual census reports handed them by nurses or other attendants, it was explained. This consists largely of checking squares with marks which indicate "yes or no" answers.

Where a patient is too ill to fill out the schedule himself, enumerators will obtain as much information as possible from the hospitals' records, the bureau said. Under the interpretation of the Census Bureau, general hospitals are special living quarters which, with minor exceptions, provide short-term medical care. Field workers of the bureau have been advised that, among the places which include the term "hospital," general hospitals are by far the commonest.

Regular census enumerators are not to be used in any places where their health or safety may be subject to risk. Where necessary, in certain institutions and general hospitals, field officials of the Census Bureau are empowered to employ staff personnel to assist in enumerating patients.

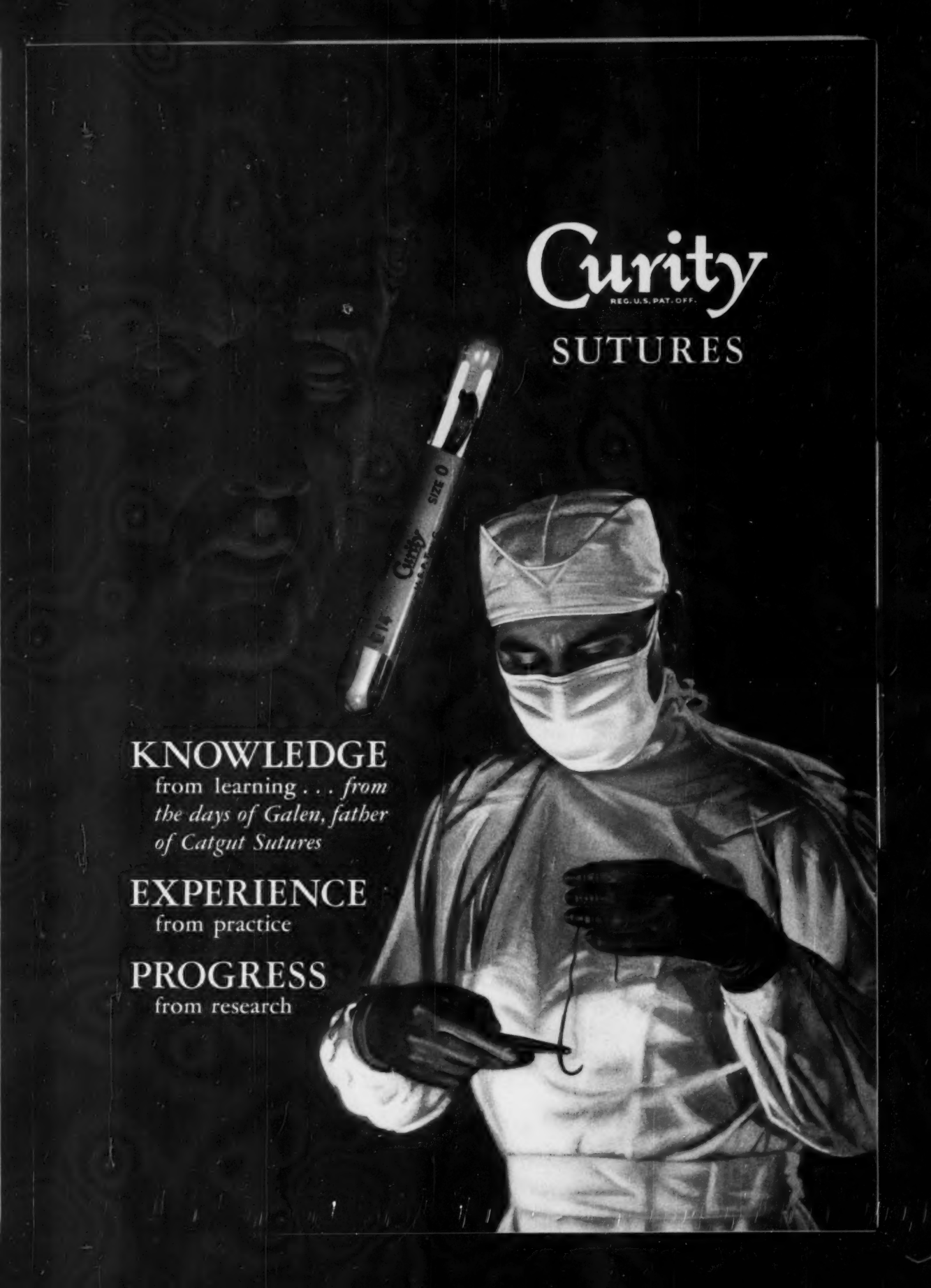
A.C.S. Approved 3284 Hospitals During 1949

CHICAGO. — A roster of 3284 approved hospitals in the United States, Canada and a few other countries was published here last month by the American College of Surgeons. This number may be compared with 3150 at the end of 1949. The announcement came at the conclusion of the 32nd annual survey conducted by the college under its hospital standardization program, Dr. Malcolm T. MacEachern, director of the college, said.

The survey list in 1949 included 3998 hospitals of 25 or more beds, of which 82 per cent are approved, the report indicated. Of the 3284 total approvals, 2981, or 74.5 per cent, are fully approved, and 303, or 7.5 per cent, are provisionally approved. Every hospital is reconsidered for approval each year under the point-rating system, by means of which every kind of service is separately evaluated, it was explained.

$2,000,000 to Cancer Center

NEW YORK.—A $2,000,000 donation to the Memorial Hospital cancer center from John D. Rockefeller Jr. was announced here recently by Reginald G. Coombe, president of the hospital. The gift completes a $5,000,000 fund needed for construction of a new clinic building, children's wing, operating rooms, recovery ward, laboratory and other expanded facilities, Mr. Coombe said. In addition, $2,000,000 is to be set aside for salaries of research and clinical staffs.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NEWS...

U.S.P.H.S. Sets Up Unit to Develop Radiological Health Program

WASHINGTON, D.C.—Formation of a new unit of the U.S. Public Health Service to develop a radiological health program to meet potential health hazards created by increased use of radioactive materials and radiation-producing machinery was announced here last month by acting Federal Security Administrator John L. Thurston. The new unit is under the direction of Dr. Edwin G. Williams, the announcement said.

The radiological health branch will correlate radiological health activities in the Public Health Service, develop a training program in radiological health for service officers and other public health workers, and act as a source of information on radiological health for other units of the service, for other federal agencies, and for state and local health agencies, it was explained.

Surgeon General Leonard A. Scheele of the Public Health Service said the new branch was established "because of the recent rapid increase in the use of radioactive materials and radiation-producing machines in hospitals, industry, experimental laboratories and other places throughout the country."

Rural Health Group to Meet in Kansas City

CHICAGO.—The fifth annual National Conference on Rural Health will be held in Kansas City, Mo., February 3 and 4, it was announced at American Medical Association headquarters here last month. The conference is sponsored by the committee on rural health of the A.M.A. in cooperation with national farm organizations.

More than 750 farm and health leaders—including representatives of health and farm groups, agricultural extension organizations, chairmen of state rural health committees, deans of medical schools, public health officials and others—will attend.

Five principal points to be covered by the conference are: (1) rural medical facilities at the local level; (2) the relation of agricultural extension service to rural health problems; (3) community responsibility for health service in rural areas; (4) methods of prepayment for health services in rural areas, and (5) the responsibility of medical schools in the rural health program.

NEWS...

2,000,000 Volt X-Ray to Be Installed in Delafield Hospital

NEW YORK.—A 2,000,000 volt x-ray machine will be installed in the new Francis Delafield Hospital here, Dr. Marcus D. Kogel, commissioner of hospitals, announced last month. The unit is being constructed in the General Electric X-Ray Corporation plant in Milwaukee and is scheduled for installation some time next year, it was explained.

The $8,000,000, 300 bed Francis Delafield Hospital is now nearing completion here, Dr. Kogel said. This hospital, which is scheduled for occupancy early in 1950, is located adjacent to the Columbia-Presbyterian Medical Center and is affiliated with the Columbia University College of Physicians and Surgeons. It is one of two new cancer hospitals nearing completion in Manhattan as a part of the current $42,000,000 hospital construction program of the department of public works.

A special room in the hospital will house the new machine, it was announced. This room is adjacent to another treatment room for the use of radioactive isotopes. The concrete wall between the treatment rooms is 2 feet thick and includes a lead plate one-half inch thick. Eighteen inch concrete walls enclose the room, and a 2 inch solid steel motor-operated door provides entrance. A common control room at one end serves both treatment rooms. The observation of patients under treatment from the control room is through special "water-sandwich" windows which are essentially 2 feet of distilled water sandwiched between lead glass 1½ inches thick. These special windows provide maximum protection from radiation for x-ray therapists, while permitting visibility into the treatment room. The floor of the treatment room is a concrete slab 30 inches in thickness, in which is embedded a lead mat.

67 Bed Addition Planned

SHEBOYGAN, WIS.—Plans for a 67 bed addition to the Sheboygan Memorial Hospital were announced here last month. The addition will be built with federal aid under Public Law 725, it was explained. The new building will include 48 beds in a chronic disease unit and 19 beds for psychiatric care.

Pearl Fisher Named President of Maine Hospital Group

WATERVILLE, ME.—Pearl R. Fisher, superintendent of Thayer Hospital here, has been elected president, Maine Hospital Association. Other appointees for the coming year are Helen N. Goodwin, superintendent, Rumford Community Hospital, vice president; Dana R. Thompson, assistant director, Central Maine General Hospital, Lewiston, treasurer, and L. M. MacDougall, assistant director, Eastern Maine General Hospital, Bangor, secretary. Miss Fisher has been empowered by the association to study the advisability of appointing an executive director to assist in coordinating the efforts of Maine hospitals on joint problems, including public relations, financing and other problems. At the same time Dr. Frederick T. Hill, of Waterville, and Donald M. Rosenberger, director, Maine General Hospital, Portland, were named to represent the hospital association on the editorial board of the Maine Medical Association. This action was taken at the request of the Maine Medical Association in order to bring the two groups closer together. Elected to the association's executive committee were Frank C. Curran, executive director, Eastern Maine General Hospital, Bangor, and Sister M. Annunciata, director, Mercy Hospital, Portland.

1000th Hospital Approved Under Public Law 725

WASHINGTON, D.C.—The Edward John Noble Hospital, Canton, N.Y., became the 1000th hospital construction project to be approved for federal aid under Public Law 725, the Hospital Facilities Division, Public Health Service, announced last month. Construction of the 51 bed hospital, at an estimated cost of $525,000, will begin late in the spring.

The Noble Hospital is the third in a system of hospitals to be constructed in upstate New York, to be known as the North Country Hospitals, it was explained. Two additional units in the system are under construction at Gouverneur and Alexandria Bay. The hospital at Gouverneur, which will have 60 beds and cost approximately $1,084,000, is expected to be completed by May and the hospital at Alexandria Bay, containing 30 beds and costing $437,000, by June.

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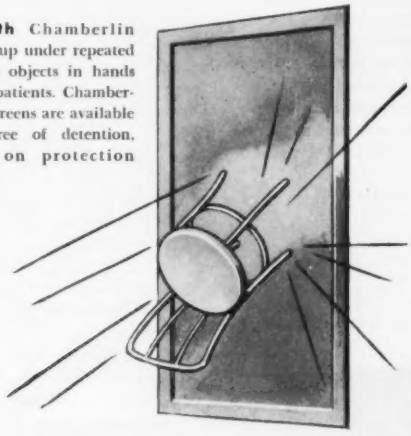

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NEWS...

National Blood Program Supplies Blood to 1550 Hospitals in 35 States

WASHINGTON, D.C. — Nearing the end of its second year of operation, the National Blood Program of the American Red Cross is supplying blood to 1550 hospitals located in 35 states, according to a report released at Red Cross headquarters here last month. More than 500,000 pints of blood for medical use have already been provided through the 30 regional programs now in operation, the report stated. First center in the program was established at Rochester, N.Y., Jan. 12, 1948.

Blood supplied through Red Cross centers is taken from voluntary donors, tested as to medical safety, typed as to blood group and Rh factor, and provided to physicians and hospitals without charge, it was explained. It is anticipated that a dozen or more additional regional centers will be opened during the coming year.

Care has been taken to assure use of all blood collected, either as whole blood for transfusion or as a source for blood plasma, the report said. In addition to the whole blood provided, vast quantities of valuable blood components, or derivatives, have been distributed. The most extensively used derivative is immune serum globulin, used either as an immunizing or modifying agent in measles. During the fiscal year 1948-49, 688,532 units of immune serum globulin were distributed by Red Cross through state health departments.

As of Jan. 1, 1950, regional blood centers were operating at Rochester, N.Y., Wichita, Kan., Stockton, Calif., Atlanta, Ga., Washington, D.C., Los Angeles, Tucson, Ariz., San Jose, Calif., Omaha, Neb., Springfield, Mo., St. Louis, Charlotte, N.C., Lansing, Mich., Detroit, Yakima, Wash., Great Falls, Mont., Columbus, Ohio, St. Paul, Nashville, Tenn., Portland, Ore., Boise, Idaho, Philadelphia, Asheville, N.C., Louisville, Ky., Syracuse, N.Y., Mobile, Ala., Johnstown, Pa., Savannah, Ga., and Norfolk, Va. The program is also operating on a statewide basis in Massachusetts.

Five Portland Hospitals Organize Council

PORTLAND, ME. — Five hospitals here have joined in an organization which will seek to coordinate hospital policy and work out mutual problems. Turner Jones, a director of the Maine General Hospital, was named chairman of the new group which will be known as the Hospital Council of Portland, it was explained.

Participating hospitals are the Maine General, Mercy, Maine Eye and Ear, Portland City and Childrens Hospital, division of Maine General.

The council will seek to promote intelligent planning and coordination in the field of community hospital service, it was explained. Additional purposes named for the council were: to serve as a forum for discussion of common problems and as a clearing house for the exchange of information looking toward the advancement of service; to interpret hospital functions to the public, and to cooperate with all agencies interested in health and social problems.

The council was organized as a result of recommendations made by Neergaard and Craig, New York hospital consultants, following a survey of hospital facilities in the Portland area.

NEWS...

$241,712,040 Paid Hospitals by Blue Cross Plans in First Nine Months of 1949

CHICAGO.—Approximately a quarter of a billion dollars, representing more than 85 per cent of income, was paid to hospitals by Blue Cross plans for care of members during the first nine months of 1949, the Blue Cross Commission reported here last month.

From a total income of $283,950,678, 90 Blue Cross plans in the United States and Canada paid $241,712,040 for members' care. Only $25,130,363 (8.85 per cent) was used for operating expenses, the report said.

More than 35,110,000 persons were enrolled in Blue Cross plans on September 30, representing more than 22 per cent of the population of the areas served by Blue Cross, the commission said.

Reese Opens Laundry Building

CHICAGO.—A new half-million dollar laundry building started operating at Michael Reese Hospital here last month. Dr. Morris H. Kreeger, director of Michael Reese, said the completed laundry is the first major hospital building to be constructed in the long-range medical center plan for the hospital. Another new building, to be completed during 1950, is the $1,850,000 Institute for Psychosomatic and Psychiatric Research and Training.

The new laundry building consists of a basement, main floor and balcony. There is a sealed room with a filtered air supply to keep all stored linen clean, and a music system throughout the plant to aid relaxation of workers, Dr. Kreeger said.

Diagnostic Center Established

NEW YORK.—A diagnostic center for ambulatory patients open to people in all income brackets was officially opened at the New York Hospital here last month. The clinic will be known as the Vincent Astor Clinic and will be used entirely for diagnostic services.

Dr. David P. Barr, physician-in-chief of the hospital, said the diagnostic service would be offered at the lowest possible price. The clinic is not operated for profit, Dr. Barr said. The entire staff of the hospital, numbering approximately 450 physicians, may be used in rendering clinic service, it was explained.

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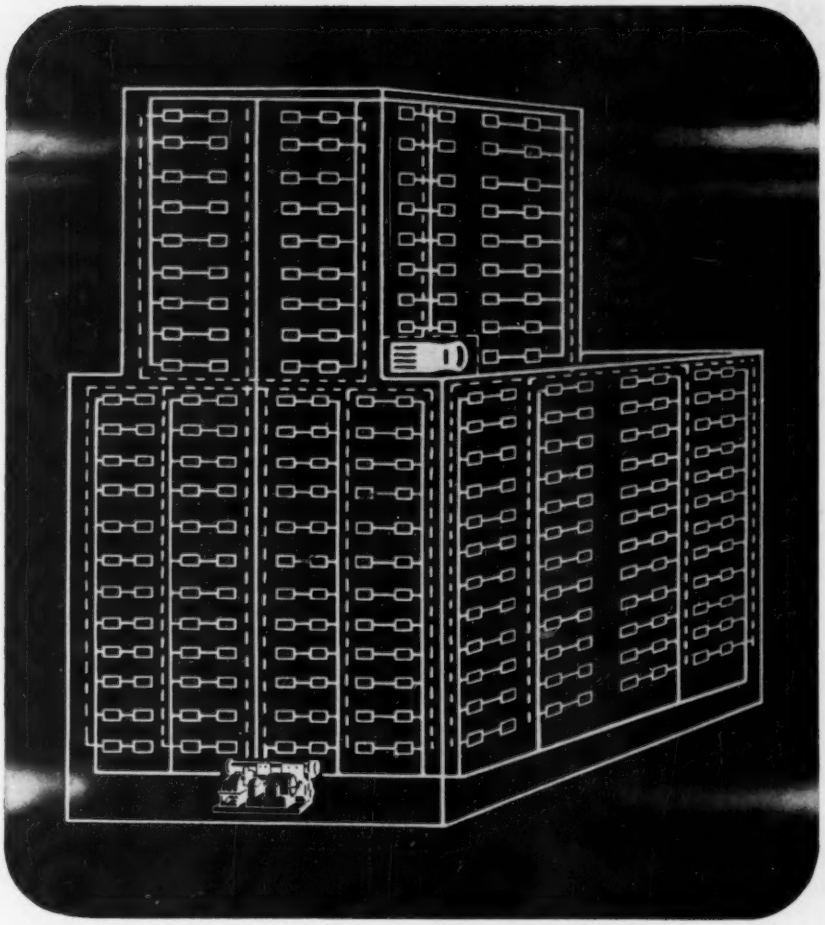

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NEWS...

Hospitals Have Obligation to Care for Indigent Sick, Dr. Pastore Asserts

NEW YORK.—All hospitals must recognize that they have an obligation to care for the indigent sick in their neighborhoods—including medical indigents as well as those actually on relief, Dr. John B. Pastore, executive secretary of the Hospital Council of Greater New York, told the *New York Times* last month. The *Times* interviewed Dr. Pastore and other hospital leaders in a survey of outpatient facilities and operations in the metropolitan area.

Dr. Pastore and other medical leaders indicated that proper utilization of outpatient facilities could relieve the load on hospital beds. "If doctors who work in outpatient departments are paid adequately for their services," Dr. Pastore declared, "the notion that a clinic competes with private physicians is automatically dispelled. The outpatient service should mean first that a diagnostic team of specialists will see the patient. He can be examined quickly and expertly and referred to a treatment clinic promptly.

"In this way we can avoid unnecessary referrals, give a large number of patients prompt and considerate treatment and release the load on our overburdened hospitals."

Dr. Marcus Kogel, commissioner of hospitals, recommended that preoperative diagnostic work-ups be done wherever possible in outpatient departments. In the case of elective operations, Dr. Kogel said, preoperative tests could be made in an ambulatory clinic with a resultant saving of "thousands and thousands" of hospital beds a year.

Acknowledging that a few hospitals operate excellent outpatient clinics, the *Times* characterized outpatient care generally as indifferent or "second rate." Estimates as to the load carried by hospital outpatient departments ranged from one-eighth to one-third of the total medical service rendered in the metropolitan area.

Transfer Mental Patients From Receiving Hospital to Relieve Overcrowding

DETROIT.—A number of mental patients were transferred to Ypsilanti State Hospital following exposure of overcrowded conditions in the male psychiatric wards at Receiving Hospital here last month. Charles F. Wagg, state mental health director, authorized the transfer as an emergency move to relieve reportedly dangerous conditions due to overcrowding at Receiving Hospital.

Dr. Thomas Hoagland, director of neuropsychiatry at Receiving Hospital, described the situation there as "imperiling the welfare of patients and personnel in the department." He reported an assault on a hospital maintenance man by a disturbed patient and a number of similar incidents caused by overcrowding.

Laundry Managers Elect

NEW YORK.—At a meeting of the Metropolitan Institutional Laundry Managers Association here last month the following officers were elected for the year 1950: president, Arthur F. Hornickel, Roosevelt Hospital; vice president, Andrew Mezei, Mount Sinai Hospital; treasurer, Gus Melish, Columbia-Presbyterian Medical Center; secretary, Frances Hayes Bayer, Henry Hudson Hotel.

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NEWS...

Welfare Department Charged With Failure in Running Orange County Hospital

SANTA ANA, CALIF.—The Orange County grand jury charged the county welfare department with failure in management of the Orange County General Hospital, a 365 bed institution. The grand jury said "chaotic conditions" existed at the hospital which had been operating for some time under the part-time management of the county welfare director.

Following investigation by the grand jury a new full-time administrator was appointed to the hospital staff. The move was recommended by the grand jury which contended that "the job of running a million and a half dollar business on half time was too much for any man, no matter how able."

The county board of supervisors named R. D. Powell as new administrator of the institution.

Six Construction Projects Planned for Milwaukee

MILWAUKEE. — Six hospital construction projects are planned for Milwaukee under Public Law 725, the state board of health announced here last month. The projects include two new hospitals and additions to four existing institutions, it was explained. The projects will add approximately 1100 voluntary hospital beds to the 1700 now in operation. The projects are:

1. A new 390 bed St. Francis Hospital to be constructed at an estimated cost of $5,800,000.
2. A new St. Luke's Hospital, 180 beds with provision for expansion to 360 beds, to be built at an estimated cost of $4,458,000.
3. A 125 bed addition to Columbia Hospital costing $1,100,000.
4. A 125 bed addition to Mount Sinai Hospital costing $2,500,000.
5. A 125 bed addition to Deaconess Hospital, $1,500,000.
6. A 32 bed addition to St. Anthony's Hospital, costing $450,000.

New Addition at Glendale

GLENDALE, CALIF.—Construction was undertaken here last month on a $500,000 addition to the Glendale Community Hospital, it was reported. The addition will contain 50 beds for general medical, surgical and obstetrical occupancy, as well as outpatient facilities.

DELAWARE HOSPITAL, Wilmington, Del.
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NEWS...

New England Assembly Will Meet March 27-29

BOSTON.—The 27th annual meeting of the New England Hospital Assembly will be held here March 27 to 29, William S. Brines, chairman of the assembly's publicity committee, announced last month. More than 5000 hospital administrators, trustees, doctors, nurses and staff members from all parts of New England and the nation are expected to attend the three-day conference.

The tentative program as announced by Paul J. Spencer of the Lowell General Hospital, chairman of the conference, will include talks by John H. Crider, Pulitzer prize winner and editor of the *Boston Herald*, and Dr. Dean Clark, newly appointed director of the Massachusetts General Hospital. In addition to the general session covering every phase of hospital operation, the assembly will hold its annual trustee institute with Lester E. Richwagen of Mary Fletcher Hospital, Burlington, Vt., assembly president, as chairman.

Discounts Given by Hospitals Vary Widely, Report Shows

CHICAGO. — Hospital practice in giving discounts to employes, staff members, trustees and other affiliated groups varies widely from institution to institution, a survey recently conducted by the Chicago Hospital Council has revealed. While most institutions give free care to student and staff nurses and interns, the nature and amount of discounts given to other groups are not uniform, the survey disclosed.

For example, 16 hospitals in the group surveyed give no discounts to trustees and their dependents; seven hospitals, on the other hand, provide free care for trustees and give a discount to members of trustees' families. Other hospitals in the group discount trustees' bills from 10 to as much as 50 per cent.

Eleven hospitals give free care to medical staff members and another 11 hospitals provide service for staff members at a 50 per cent discount. Other hospitals give smaller discounts to staff members, and most of the institutions provide some courtesy discount to members of doctors' families.

Among other groups commonly getting some discount were clergymen, doctors outside the medical staff, and nurse alumnae. Hospital employes were also included in the discounted groups in most cases.

NEWS...

Antibiotics May Cause Embolisms, Ochsner Says

NEW ORLEANS.—Increasing incidence of thrombo-embolism and the increasing number of fatalities caused by pulmonary embolism may be due to increased coagulability of the blood resulting from administration of antibiotics to hospital patients, Dr. Alton Ochsner of Tulane University's medical school, said here in a recent report to the 13th Congress of the International Society of Surgery. Dr. Ochsner described thrombo-embolism as the main postoperative cause of death and a "devastating complication" of many medical conditions, particularly of heart disease. He reported results of a study of 580 cases of thrombo-embolism of which 203 cases resulted in pulmonary embolism deaths.

His investigations suggested that increased coagulability of blood was a factor in the incidence of embolisms and that other experiments had revealed that patients receiving penicillin injections exhibited increased coagulability.

Dr. Ochsner also reported on research demonstrating that auremycin "when administered to patients and to animals caused a definite shortening of blood coagulation time."

Consultant to Guy's Hospital

CHICAGO.—Paul G. Burt of the firm of Fugard, Burt & Wilkinson, architects, has been appointed honorary consulting architect to Guy's Hospital, London, it has been announced here. Guy's Hospital was partially destroyed by German air raids during the war and Mr. Burt's appointment will take him to England to assist in the reconstruction program for the 800 bed institution which has served the sick poor of London since 1724, the announcement said.

To Build Diagnostic Center

PHILADELPHIA.—Construction of a $1,500,000 diagnostic center has been undertaken here to provide preventive medical service for 25,000 clothing workers in the Philadelphia area. The project is a joint venture of the Amalgamated Clothing Workers of America, C.I.O., and the Philadelphia Clothing Manufacturers' Association. Funds for construction of the diagnostic center have been accumulated by means of contributions collected during the last three years from union members and manufacturers employing them, it was reported.

C.S. for Plastic Wall Tiles

WASHINGTON, D.C. — A recommended commercial standard for plastic wall tiles and adhesives has been submitted by the commodity standards division of the National Bureau of Standards to manufacturers, distributors, users and other interested groups for their consideration and acceptance, the bureau announced last month. The recommended standard establishes minimum quality through approved methods of test, materials, requirements for workmanship, tolerances, thickness, opacity, internal stress, colorfastness and other details of manufacture, which should ensure a satisfactory product for wall or ceiling installation where a non-absorbent, sanitary surface is desired, it was explained. Requirements for the adhesives to be used for installing the tile are also covered in this recommendation.

FOR MAXIMUM COMFORT AND ABSORBENT CAPACITY

CAROLINA

SANITARY NAPKINS

for all hospital uses

All cotton filler—knitted tubular cover

Improves with sterilization

CAROLINA SANITARY NAPKINS, made by specialists in cotton, provide unequalled comfort and absorbent capacity for all hospital uses.

These napkins are all cotton, specially treated to provide the downy-soft comfort and absence of chafing and irritation so necessary in surgical or obstetrical cases. Each cotton napkin is enclosed in a strong, tubular knitted stockinette jacket, which is not merely a wrap-around cover but entirely encloses the cotton.

Carolina Sanitary Napkins do not shrink or become brittle when sterilized. Actually heat makes them bigger and fluffier. And to give maximum absorbency and quicker, longer protection, the center of each pad contains a specially designed cellulose filler.

Try Carolina Sanitary Napkins for greater patient comfort—and lower costs in your hospital. Provided in three standard sizes. Banded in dozens—100 dozen per carton. If you are not using Carolina Sanitary Napkins now, ask the Carolina representative or write for samples and further information.

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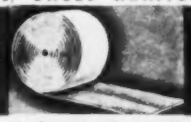

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Quality comes first in Carolina-Maid apparel, starting with the specially-selected fabric. Then, every construction detail is designed for long, comfortable service. Every stress point is bar-tacked. All joining seams are two-needle seams, locked and bolted down. Each yoke is put through two extra sewing operations to insure strength and permanance. Tie tapes are put in so solidly that the fabric will give first. Even the hems are tough, turned over and double sewn. Literally, Carolina-Maid apparel will not fall apart at the seams.

Comfort, too, is provided. Carolina-Maid apparel is generously cut and sizes run full, giving ample room for easy action. A trial of Carolina-Maid apparel will convince you that maximum wearability and resistance to hospital laundering is built into these garments. Send for the new illustrated catalog and prices today.

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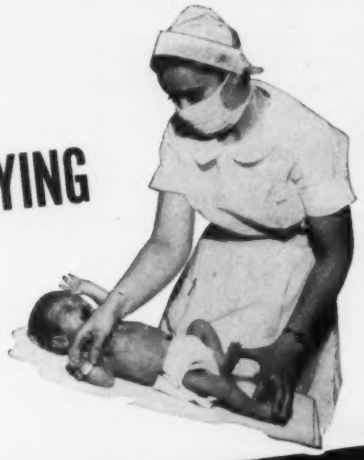

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NEWS...

N.J. Hospitals Work Toward Eliminating Race Prejudice

NEWARK, N.J.—New Jersey hospitals were credited with progress toward elimination of racial discrimination in a report issued here last month by the state department of education in cooperation with the New Jersey Hospital Association. The report summarized reports of a survey covering admission and placement practices in 85 voluntary hospitals located in 21 counties throughout the state.

Some discriminatory policies exist in hospitals, it was reported, but "the trend seems to be toward nondiscrimination where hospitals are concerned," the report said.

Among the findings were:

1. Twenty-five hospitals would not place Negro and white patients in the same facilities under any circumstances, while 54 hospitals assigned Negro and white patients to the same semiprivate accommodations.

2. Seventy-eight hospitals admitted Negroes freely to private rooms; some hospitals were found to give Negroes private rooms at the cost of semiprivate accommodations to avoid anticipated objections by white patients. Four hospitals barred Negroes from private rooms.

3. Of 45 hospitals with schools of nursing, 16 had Negro students, 32 had Jewish students and 38 had Italian students. Some hospitals reported reluctance to mix races in nursing school dormitories but all the schools which did have interracial residences reported favorably on the experience.

Practices in a number of hospitals and nursing schools were liberalized during the period covered by the survey, it was reported. Negro girls were being accepted in training schools which had previously barred them and minority group members were appointed to staff positions.

COMING MEETINGS

ALABAMA HOSPITAL ASSOCIATION, Hotel Jefferson Davis, Montgomery, Feb. 24, 25.

AMERICAN HOSPITAL ASSOCIATION, Atlantic City, Sept. 18-21.

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 10, 11.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Congress Hotel, Chicago, March 1-3.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION, Hotel Peabody, Memphis, Tenn., May 23-27.

ASSOCIATION OF WESTERN HOSPITALS, Olympic Hotel, Seattle, April 24-27.

BOARD OF METHODIST HOSPITALS AND HOMES, Congress Hotel, Chicago, March 1, 2.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Frances Marion Hotel, Charleston, S.C., May 11, 12.

CATHOLIC HOSPITAL ASSOCIATION OF AMERICA, Milwaukee Auditorium, Milwaukee, June 11-15.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 21.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, March 28-30.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Oct. 30, 31.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Memorial Auditorium and Convention Hall, Buffalo, N.Y., May 24-26.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 12-14.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 27-29.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, March 22-24.

SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 5-7.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, March 7-9.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, Feb. 16.

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Perfectionism is part and parcel of the medical creed. A reputable physician uses every bit of his medical skill and knowledge when he treats a patient. When new and better techniques are discovered, he makes it his business to acquire and use them.

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MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER

NEWS...

Conduct Hearings on Davenport Hospital Fire

(*Continued From Page 68.*)

mated by fire authorities to be in the neighborhood of $200,000.

The fire was confined to the St. Elizabeth Ward, one of five buildings on the hospital grounds.

Davenport Fire Marshal O. G. Mangels said a recent inspection showed the building was in first class condition from a housekeeping standpoint. Recommendations of the department had been complied with, he said, with the exception that a recommendation for the installation of an automatic sprinkler system had not been followed. The sprinkler system was not required under the city's fire safety code, it was pointed out.

Those testifying as the hearings opened were Sister Mary Annunciata, superintendent of the hospital, Sister Mary Gabriel, and William Blunk, contractor in charge of the newly completed remodeling project. The building did not include any partitions of materials unacceptable under modern building codes, it was learned.

Recommend Standard for Hardwood Doors

WASHINGTON, D.C. — A proposed commercial standard for hardwood veneered doors is being circulated by the commodity standards division of the National Bureau of Standards to manufacturers, distributors and other interested groups for their review and comment, the division announced here last month. The purpose of the standard is to establish standard specifications for panel, sash and flush stock doors made from veneered hardwoods as a guide for producers, distributors, architects, builders and other interests, it was explained. It will cover construction, grades, sizes, tolerances and labeling, and layouts and designs for both interior and exterior doors, as well as for sidelights, are included.

Adds Five-Story Wing

MONROE, WIS.—A five-story, $890,000 wing now being added to St. Clare Hospital here will increase the hospital's present capacity by two-thirds and provide 50 additional private rooms for patients, it was announced last month by Sister Superior M. Evarista, hospital superintendent.

NEWS...

Health Insurance Plan Adds 100,000 Members

NEW YORK.—Nearly 100,000 new members joined the Health Insurance Plan of Greater New York in 1949, President David Heyman reported here last month. Membership now totals approximately 230,000.

H.I.P. dispensed $3,985,000 in medical services to subscribers during the year. This amount was paid to physicians for approximately 850,000 services rendered to subscribers. Approximately 40 per cent of service was rendered by specialists, the report said.

"H.I.P. experience offers further evidence that medical group practice is the most effective way to provide high quality, comprehensive medical service at reasonable cost," Dr. George Baehr, chairman of the plan's board, stated. "Moreover, this modern method of private practice eliminates the financial barrier between physician and patients and enables medical groups to develop a sound program of preventive care for subscribers."

New England Center Hospital Opens Prevention Clinic

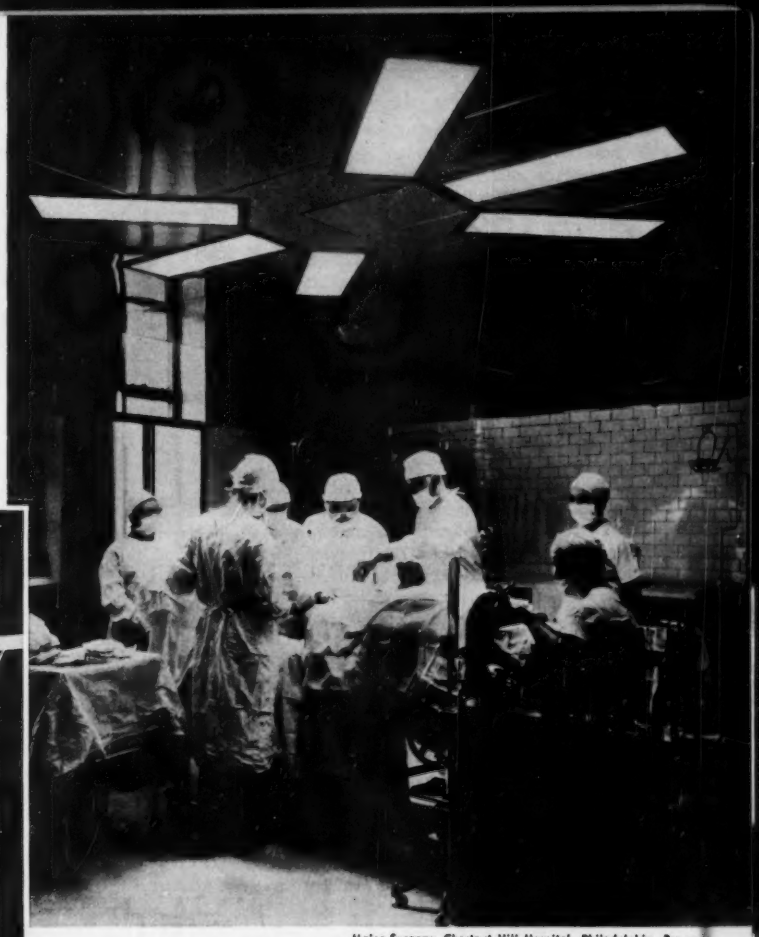
BOSTON. — A preventive medicine clinic, believed to be one of the first in the country open to the general public, was opened here last month at the New England Center Hospital. The clinic is sponsored jointly by the Massachusetts Medical Society and the State Department of Public Health, it was explained. It will be open to any person 18 years old or over who is not under the care of a private physician and will provide general medical examinations.

No diagnosis will be given to the patient as a result of the "health protection" examination, hospital officials said. However, if tests indicate the presence of a disease, the patient will be urged to consult a physician and reports of tests will be forwarded to the doctor. No charge is made for the examinations. It is expected that approximately 3000 examinations will be conducted during a trial period of operation lasting through June 1950.

Home Care Program Aids Municipal Hospitals

NEW YORK.—Despite the greatest patient load ever cared for by municipal hospitals here, they were able to hold the line and were not forced to

The NEW HOLOPHANE SURGERY LIGHTING SYSTEM Provides Most Effective, Economical, Dependable Illumination

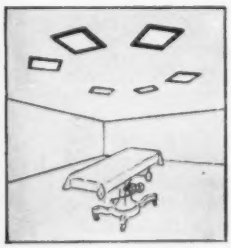


Major Surgery, Chestnut Hill Hospital, Philadelphia, Penna.

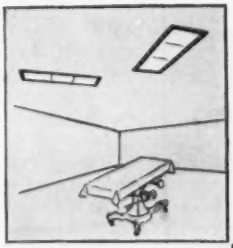
Wide distribution of light sources insures rays that approach the wound area from many different directions, free from normal interception by personnel about the table.

Eighteen Beams Concentrate Glareless, Shadowless, Comfortable Light on the Operating Area . . .

The Holophane Major Surgery Lighting System consists of 6 triple CONTROLENS* units with eighteen light beams which converge to provide (1) a high intensity spot on the operating area (2) a wider area of gradually diminishing light over the entire table (3) correct degree of balanced general illumination throughout the surgery . . . The light on the operating table is without glare, interfering shadows or objectionable heat . . . Location of the lighting system remote from the anaesthetization zone eliminates hazards of explosion; multiple lamping minimizes danger of interruption from lamp burnouts . . . The system is economical to maintain, easy to keep clean. Built-in ceiling arrangement gives the entire room a neater, more modern appearance.



Sketch showing Holophane Emergency or Minor Surgery System



Sketch showing Holophane Delivery Room System

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turn away a single patient requiring emergency care in 1949, principally because of the home care program launched last year, Dr. Marcus D. Kogel, commissioner of hospitals, said in releasing the annual report of the department of hospitals last month.

The report reviews the department's reorganization instituted a year ago following a study and recommendations made by the Bureau of the Budget. It states that 7,213,139 patient days' care were provided in 1949 compared with 7,110,787 in 1948; that clinic or outpatient visits totaled 2,065,581 last year as against 1,822,992 in 1948. The report stresses a four point program to relieve the "twin plagues of overcrowding and obsolescence." The program includes home care, rehabilitation, expansion of outpatient services, and relieving x-ray and laboratory bottlenecks.

Research Building at M.G.H.

BOSTON.—Construction was undertaken here last month on a new research building at Massachusetts General Hospital. The new building will be devoted to investigation of the diseases of old age, the hospital reported. The building is expected to cost $2,750,000.

ABOUT PEOPLE

(*Continued From Page* 78.)

dent of the Panhandle Hospital Council last year, formerly was superintendent of the Childress General Hospital, Childress, Tex.

W. K. Howard

Walter Kenneth Howard of Colorado Springs, Colo., has been named assistant manager of the Colonial Hospital, Rochester, Minn. His appointment was announced by **Roy Watson,** president and general manager of the Kahler Corporation, which operates the hospital.

Department Heads

Dennis Fennelly has been named employe relations manager of Pennsylvania Hospital, Philadelphia.

Vivian M. Duxbury, R.N., director of nursing at New Britain General Hospital, New Britain, Conn., from August 1946 to August 1949, is now director of nurses at Orange Memorial Hospital, Orlando, Fla. **Cynthia Bishop** also became associated with Orange Memorial recently when she joined the staff as chief dietitian.

Mrs. Patricia M. Boyer has been named executive housekeeper of Walter Reed Hospital, Washington, D.C. She was previously executive housekeeper at Meriden Hospital, Meriden, Conn.

Peter Bozzo has replaced **Guy B. Condon** as purchasing agent of Presbyterian Hospital, New York.

Louis Gdalman

Louis Gdalman has been appointed director of pharmacy at Michael Reese Hospital, Chicago. Mr. Gdalman had been assistant director of pharmacy at St. Luke's Hospital, Chicago, from 1930 until joining Michael Reese January 1.

Marion Denitz has replaced **Gertrude Binder** as director of the department of public interest, Cedars of Lebanon Hospital, Los Angeles.

Neva E. Nye, formerly educational director at Presbyterian Hospital of Pittsburgh, became superintendent of nurses and director of the school of nursing at San Diego County General Hospital, San Diego, Calif., December 1. She succeeds **S. Bessie Barnes,** who retired from that position after 20 years of service.

L. W. Hammett has been named purchasing director and supply control officer at Michael Reese Hospital, Chicago. For four years Mr. Hammett served as acting assistant director of Mount Sinai Hospital, Baltimore, in charge of purchasing and control of supplies and equipment.

Miscellaneous

Dr. Harvey Agnew has resigned as executive secretary of the Canadian Hospital Council and editor of the Canadian Hospital, to join the consulting firm of Neergaard and Craig, New York City, which will henceforth be known as Neergaard, Agnew and Craig. Dr. Agnew had served as executive secretary of the council since its inception in 1931. He is a past president of the American Hospital Association and has served on a number of its councils and committees. He is an honorary fellow of the American College of Hospital Administrators. Dr. Agnew will continue on a part-time basis with the Canadian Hospital Council until next June.

George W. McLester, a real estate man, has been appointed executive director of Chicago's west side medical center. He succeeds the late **Walter J. Kelly,** who died a year ago.

Colson Trucks for Fast, Quiet Handling of Trays and Dishes

Now Stainless Steel for Sanitation, Durability and Appearance

★ **Sanitary** — *easy to clean — no cracks or crevices to invite bacteria.*

★ **Durable** — *life-time finish, sturdy welded construction, rugged wheels and casters.*

★ **Bright** — *cheerful, rust-proof stainless steel.*

Model 10 — 6332 Stainless Steel Tray Truck . . . Corner posts are 1¼" diameter stainless steel tubing. Heavy gauge shelves have double thick edges for extra strength and an embossed recess helps keep trays in place. Heavy-duty rubber bumper protects truck, other equipment and walls. Swivel type ball-bearing casters with cushion-rubber tires float heavy loads quietly—effortlessly. This deluxe tray truck is one of over 30 different COLSON models.

Model 10 — 6406-6 Stainless Steel Dish Truck . . . These Colson dish trucks are attractively styled and sturdy enough to provide many years of efficient service. Edges are double thick for extra strength, frame is 1¼" tubular stainless steel, shelves are 16 gauge type 302 stainless-clad. All joints are welded, ground smooth and polished. Front wheels are 10" diameter, rear wheels are 5"—all have replaceable cushion-rubber tires and ball-bearing hubs to insure fast, quiet operation.

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WHEEL CHAIRS • WHEEL STRETCHERS • INHALATORS • TRAY TRUCKS • DISH TRUCKS • INSTRUMENT TABLES

Dr. John F. Mahoney, former director of the venereal disease research laboratory of the United States Public Health Service, has been appointed commissioner of health of New York City, succeeding **Dr. Harry S. Mustard.** Dr. Mahoney retired recently from the United States Public Health Service, in which he had served since 1917.

Dr. A. William Reggio, chief, Physical Medicine and Rehabilitation Branch, Division of Hospitals, U.S. Public Health Service, will retire on Feb. 1, 1950, after having reached the service's mandatory retirement age (64). Currently, he holds the grade of medical director, comparable to the rank of colonel in the army. His successor has not been named.

Maj. Gen. Hugh J. Casey took office January 3 as executive vice president of Pennsylvania Hospital, Philadelphia. General Casey retired December 31 from the Corps of Engineers, U.S. Army.

Dr. Robert T. Stormont has succeeded **Dr. Austin Smith** as secretary of the Council on Pharmacy and Chemistry of the American Medical Association. Dr. Stormont, medical director of the Federal Food and Drug Administration, Washington, D.C., jointed the Pure Food and Drug Administration in 1946.

H. G. Klene

Homer G. Klene has been appointed executive secretary and assistant to the president, American Surgical Trade Association. Mr. Klene was graduated from Washington University, St. Louis, and practiced law in that city from 1929 to 1940. He became secretary of the Marking Service Association in 1940, a position he left in 1945 to become western group secretary of the Folding Paper Box Association. In 1947 he joined the staff of the Metal Stamping Research Institute as executive director. **Fred Hovey,** secretary of the A.S.T.A. for 40 years, will remain as consultant to the new executive secretary.

Deaths

Ethel Katherine Bacon, former president of the New York State Board of Nurse Examiners, died in Trudeau, N.Y., December 11 at the age of 57 years.

Mother Grace of the Missionary Sisters of the Sacred Heart, for the last 25 years Superior at Columbus Hospital, Chicago, died in Rome, where she had gone for the Holy Year. She also was a delegate to the Mother General of the order.

Charles M. Hoffman, retired hospital superintendent and former deputy commissioner of the New York State Veterans Bureau, died after a long illness. He was 70 years old.

Dr. Harry Hascall Moore, who directed the Research Council on Problems of Alcohol from 1938, when it was organized by the Association for the Advancement of Science, until 1946, died in Bronxville, N.Y., December 27 at the age of 68. He was the author of several books, among them "Public Health in the United States," "We Are the Builders of a New World," and "Survival or Suicide."

John A. Lindner, administrator of Hilo Memorial Hospital, Hilo, Hawaii, died suddenly in Honolulu January 5. He was 54 years old. Previous to his association with Hilo Memorial, Mr. Lindner held administrative positions with Doctors Hospital, Washington, D.C.; Laconia Hospital, Laconia, N.H., and the Weld County Hospital in Greeley, Colo.

Lawrence J. Morris, a member of the board of managers of Pennsylvania Hospital, Philadelphia, for nearly 29 years, died recently. He served as secretary of the board for more than 26 years.

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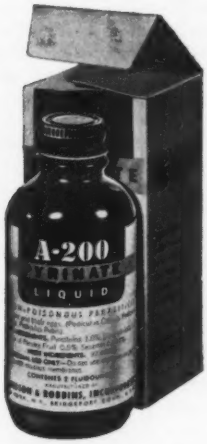

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The active ingredients of A-200 are Pyrethrum extract activated with Sesamin, Dinitroanisole and Oleoresin of Parsley fruit, in a detergent water soluble base. The pyrethrins are well-known insecticides and Anisole is a well-known ovicide, almost instantly lethal to lice and their eggs, but harmless to man. The efficacy of A-200 was proved in 8,000 clinical cases in the District of Columbia jail.

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THE BOOKSHELF

MANUAL OF OPERATION FOR HOSPITAL LAUNDRIES. *Prepared by the Committee on Laundry Management of the Council on Administrative Practice, American Hospital Association.* 1949.

This splendid, practical, up-to-date manual which has just been distributed to members of the American Hospital Association warrants careful study by every hospital administrator, assistant administrator, purchasing agent and laundry manager. The following quotations from the foreword as written by Sister Mary Reginald, chairman, Council on Administrative Practice, are particularly worthy of note. "True, many hospitals have heretofore operated fine laundries even though they lack the yardstick or a volume on standards with which to evaluate accurately the work being done. The inclusion of time studies of operation equipment and of piece handling brings into focus an economical element of laundry management that is not often thought of by the busy administrator but which can be easily reflected in the hospital operating statement."

Chapter 1 covering linens offers a valuable reference and educational tool for those who want to know something about the technical and practical side of linens.

Chapter 2 on washroom practice starts out with an excellent, common sense discussion of problems of water softening. I believe that this particular section would have been strengthened by the inclusion of clear-cut economic facts of money to be saved through the use of soft water in the laundry. The section on laundry supplies takes much of the mystery out of such common place items as alkalis, proprietary alkalis, laundry soaps, sours and starches. The section on tested washing formulas is particularly worthy of note. The discussion on the multiple suds principle and the value of test pieces is most interesting and worth while. The presentation of facts on the value of pipe sizes and water pressures is very important.

Chapter 3 on the public health aspects of the laundry certainly presents many things that most people have never given sufficient thought to. The list of precautions to be considered in the hospital laundry from the standpoint of public health is of real interest.

No one should miss chapter 4 covering textile damage in the laundry owing to mechanical and chemical reasons.

On page 132, the washer capacities given seem to contradict those given on page 86. The capacities as given on page 132 are higher than the capacities given on page 86 and seem to be more nearly in keeping with the standard rating on washers as given by the manufacturers. As an example of this, on page 85, last paragraph, the 42 by 86 inch washer is rated at 270 pounds' capacity where manufacturers rate this size washer at 300 to 350 pounds' capacity. I believe that this discrepancy should be cleared up through careful investigation.

For those interested in water repellents, the treatment of this subject on page 128 is worthy of note.

The chapter on finishing is noteworthy for its giving of actual produc-

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are the only wood-faced doors that carry the Underwriters' Label for Class "B" openings. Special construction with fireproofed edge-banding and mineral composition core gives you absolute fire protection in approved installations. Cross bandings and facings are bonded with waterproof phenolic glue that enables this door to withstand moisture indefinitely.

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Utilizes the same core material as the Weldwood Fire Door but edge bandings are not fireproofed. Recommended for locations where a labeled door is not required. Standard thickness: 1¾". Also available in 2¼", 2" and 1⅜".

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tion standards to guide hospital administrators and laundry managers in checking up on the efficiency of their own operation.

Chapter 7 entitled "Opportunities for Economy" is a real gift to everyone interested in operating hospital laundries. In the chapter on machinery and equipment, the discussion on automatic sheet, spread and small piece folders and on small piece stackers is something to make everyone sit up and think about. The possibilities of labor saving and reduction of number of people on the laundry pay roll through the use of this type of equipment should command the attention of everyone.

The section on suggested minimum machinery equipment needs for hospitals of varying bed capacities is splendid. The equipment check lists for the 50, 100 and 200 bed hospital follow closely the information given in the current edition of the *Hospital Purchasing File*. This list, however, is more comprehensive in that it also covers equipment check lists for 500 and 1000 bed general hospitals.

A small pony washer should have been included in the list for the hospitals of 100 beds and under. In the 50 bed hospital check list a 36 by 36 inch washer is recommended. This is undoubtedly the correct size. A small washer of only 25 pounds' capacity might well be provided as there are many small lots which require special formula, such as baby diapers and similar items. It seems to me it might be a real economy to have a small washer in addition to the 36 by 36 inch unit recommended.

Everyone in the hospital field is indebted to the A.H.A.'s Committee on Laundry Management for the preparation of this splendid manual.—E. W. JONES.

NUTRITION AND PHYSICAL FITNESS. *By L. Jean Bogert, Ph.D. Philadelphia 5: W. B. Saunders Company,* 1949. *Fifth Edition. Pp.* 610. *Price* $4.25.

Here is another welcome addition to the dietitian's reference shelf, in which the theoretical and the practical aspects of the science of nutrition are presented in a highly readable form which at the same time will be understandable to the layman with little or no knowledge of chemistry. The five sections are headed: "Foods," "Body Needs," "Body Processes," "Meal Planning," and "Diet for Special Conditions." The attractive format and easy-on-the-eyes typographical arrangement serve as well to make the book a pleasant means of absorbing a refresher course on nutrition.

In line with advancing knowledge, protein and protein needs are stressed, the chapters on the vitamins have been largely rewritten, those on the minerals have been brought up to date, and chapters on food economics and trends in food habits have been markedly revised. Other sections have also been revised, certain new sections added, and as a special feature of this edition, questions, problems and lists of suggested readings have been appended to each chapter. This last will, of course, materially aid the student and teacher. It is encouraging to note that in the chapter on "Food Accessories" alcoholic beverages, which are listed with their caloric values, and caffeine-containing soda fountain drinks are both cited as possibly harmful habit-forming beverages. Other chapters which doubtless will have special appeal to the average reader are those on "Food Fads and Fancies," "Diet After Forty," "Overweight: Its Significance and Treatment," and "Malnutrition: How to Detect and Overcome It."

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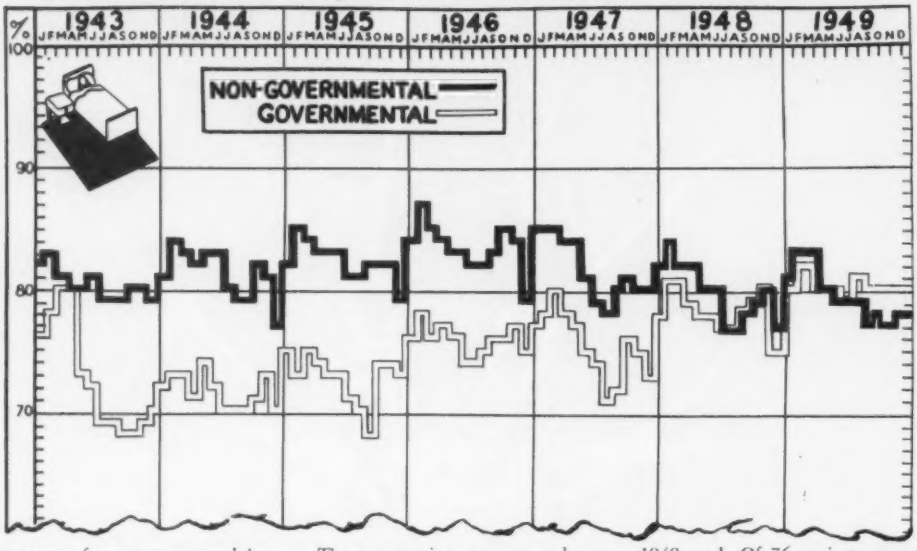

Occupancy of nongovernmental hospitals reporting to The MODERN HOSPITAL was 77.7 per cent of capacity for the month of December, down slightly from the previous month. Governmental hospital occupancy was 79 per cent.

The construction year got under way with $66,326,883 in hospital projects reported for the initial 1950 period. This amount was 25 per cent greater than the total for the same period last year, and 35 per cent more than the 1948 total. Of 76 projects reported in January, 20 were new hospitals, 52 were additions to existing institutions, three were nurses' homes, and one was a remodeling project. Average cost of the new hospitals was $1,000,000 each.

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New Broom, New Technique Cuts Floor Sweeping Time

A new broom-type instrument that cleans in a new, more thorough manner, is now available to reduce sweeping time in hospital corridors and ward rooms.

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As its name implies, the Damp-Sweep Tool is designed for damp-sweeping—a technique in which a dampened cloth is used under the broom. This technique has proved superior to brush sweeping for removing fine dust from floors, and preserving the finish from soiling. The Damp-Sweep Tool is the first instrument created specifically for damp sweeping.

The tool comes with a 40" square of cloth with a taped hole at its center. The cloth is slipped down over the Tool's handle, which projects through the hole, and is wrapped around a specially designed brush element so that it lays on the floor. The brush's bristles are arranged to hold the cloth to the floor.

To sweep, the instrument can be walked in long, straight strokes or swung in wide arcs. The swiveled handle permits a sweeper to manipulate the instrument in arcs, under furniture and around obstructions with a twist of the wrist. Whole areas are swept without a break in stride or sweeping rhythm, and sweeping time is reduced as much as one-third.

The Damp-Sweep Tool is available to hospitals only through sales offices of the Walter G. Legge Co., Inc. For full details, write "Damp-Sweep Tool" in the coupon to the left, clip to your letterhead and mail.

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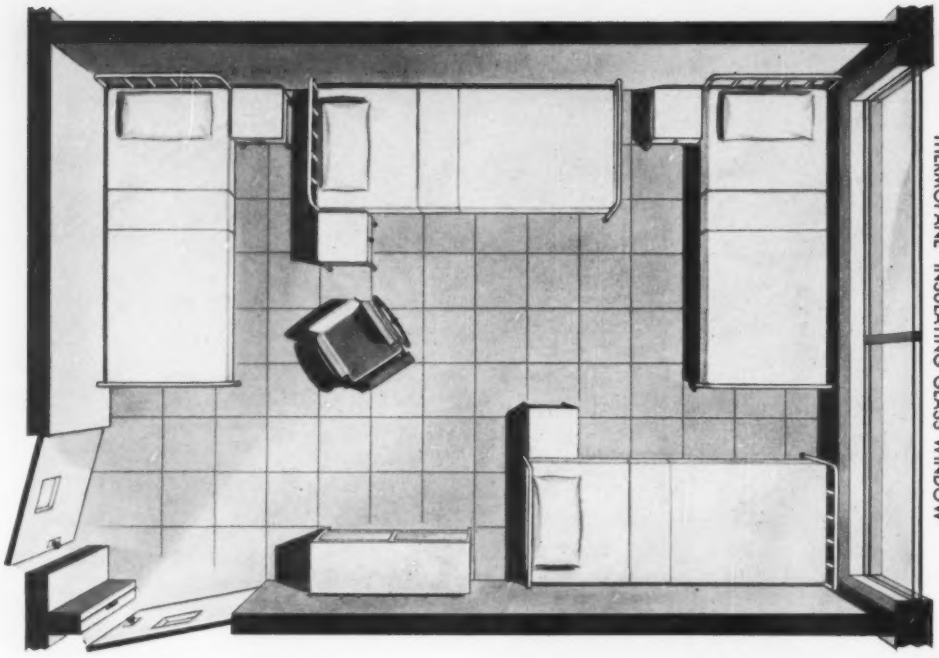

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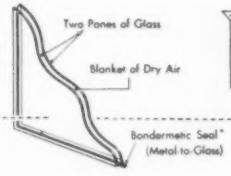

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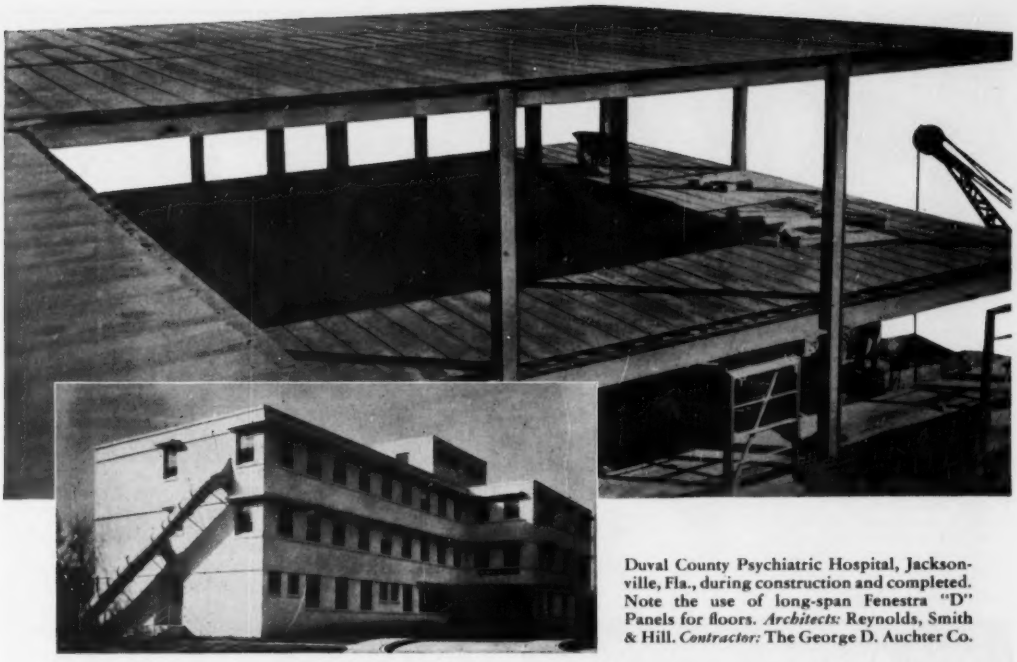

Duval County Psychiatric Hospital, Jacksonville, Fla., during construction and completed. Note the use of long-span Fenestra "D" Panels for floors. *Architects:* Reynolds, Smith & Hill. *Contractor:* The George D. Auchter Co.

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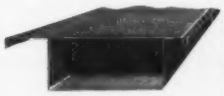

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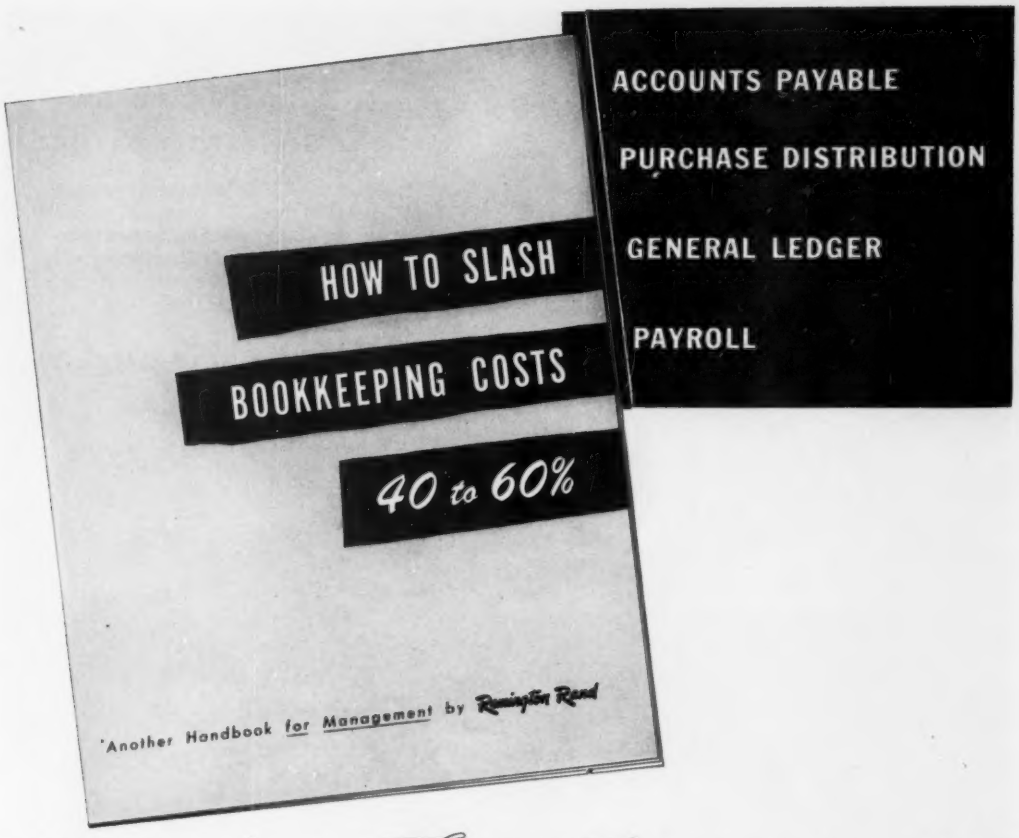

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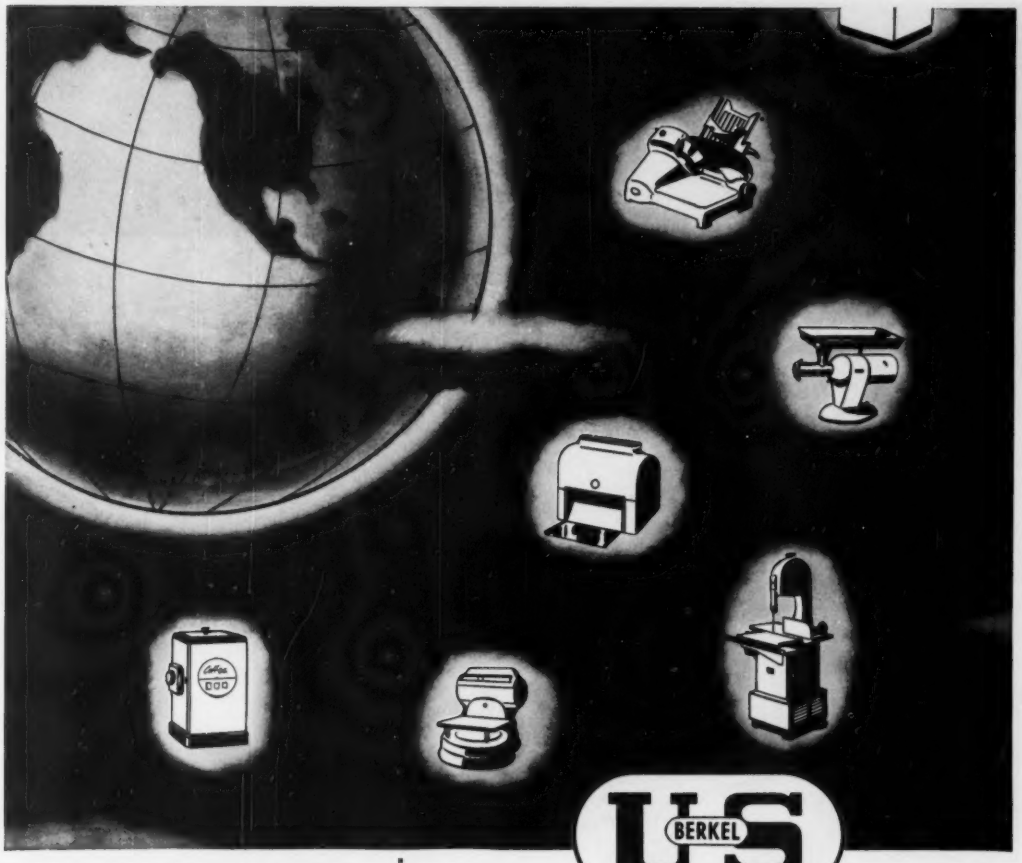

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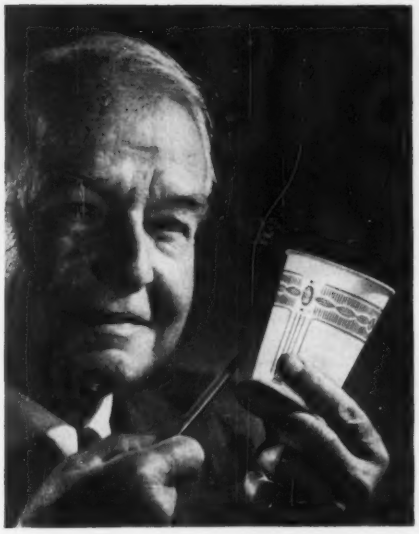
The costs of food service can be cut by using Dixie Cups and Food Containers. You save labor costs by reducing the amount of necessary washing, sterilizing, drying, and stacking. You cut food costs by using the proper size Dixie to assure accurate portion control. You save time since Dixies are always ready for use, are handled easily and speedily. There's never any time lost waiting for Dixies! Too, tight-fitting Dixie lids protect food and hold it at peak of flavor and freshness until served. Yes, you save dollars with Dixie paper service.



DIXIE CUP SERVICE
IS BETTER SERVICE BECAUSE IT'S...

SMOOTHER—Fewer delays in kitchen resulting from clutter of unwashed dishes or help shortages. Fewer complaints resulting from the service of foods and beverages at distasteful temperatures.

QUICKER—Dixies are always ready for instant use. Handling is speedier, trays are lighter.

QUIETER—No disturbing clatter of dishes when you use Dixies.

CLEANER—Used but once. Always fresh and appealing.

SAFER—Constant protection from mouth-borne infections.

THRIFTIER—*Saves time, labor*—Greatly reduces dishwashing. Cuts clean-up, sterilizing, storing time by hours a day. *Saves food*—No waste through careless over-portioning. *Saves materials*—Less soap, detergents, hot water needed. No breakage, calling for constant replacements.

the trend is to

DIXIE CUPS

MOST WIDELY ADVERTISED...
MOST POPULAR OF PAPER CUPS

For complete information on paper service, write Dixie Cup Co., Easton, Pa.

DIXIE CUP

"Dixie" is a registered trade mark of the Dixie Cup Company

COLD DRINK DIXIE CUPS for fruit and vegetable juices

COLD DRINK DIXIE CUPS for milk and soft drinks

HOT DRINK DIXIE CUPS for coffee, tea, cocoa

PAC-KUP FOOD CONTAINERS for soups, stews, main dishes

ICE CREAM PAC-KUPS for pre-packed serving of ice cream

DIXIE DESSERT DISHES for ice cream, stewed fruits and puddings

Around the Wards with Kellogg's

Patient Barbara:

Ummmm! Just like home! My favorite breakfast! (Kellogg's Cereals *are* a tasty treat. Hospital records show that they're favorites with patients the country over.)

Nurse Jones:

Thank goodness for Kellogg's Individuals! They save me so much time with breakfast. There's a choice for everyone in the Kellogg line—and they're a cinch to serve.

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Breakfast planning is so much easier with Kellogg's big assortment of flaked, shredded and popped cereals. All Kellogg cereals either are made from the whole grain or are restored to whole grain levels of thiamine, niacin and iron!

MORE PEOPLE PREFER Kellogg's

Be sure your wholesaler salesman keeps your assortment of Kellogg's complete at all times.

KELLOGG'S CORN FLAKES · RICE KRISPIES · PEP · KELLOGG'S 40% BRAN FLAKES · CORN-SOYA KRUMBLES · KELLOGG'S SHREDDED WHEAT · KELLOGG'S RAISIN BRAN FLAKES · ALL-BRAN

3-Way Approval Makes Hospitals choose C.P.P. toilet soaps!

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PALMOLIVE—requested, enjoyed, made popular by millions—meets the highest hospital standards in purity—a favorite with patients and nurses alike!

CASHMERE BOUQUET is a big favorite in private rooms and pavilions because women like the delicate perfume of this hard-milled luxury soap.

COLGATE'S FLOATING SOAP is made especially for hospital use—meeting the most exacting requirements for purity, mildness and economy.

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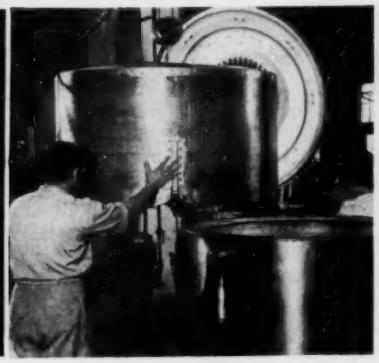
***LINENS ARE AUTOMATICALLY** washed sterile-clean in this American Cascade Automatic Unloading Washer with Companion Control, then unloaded automatically into Notrux extractor containers.*

***EXTRACTOR CONTAINERS** with washed work are quickly conveyed by hoist and overhead rail then lowered into Notrux extractor. Photos courtesy of American Laundry Machinery Company and Queen of Angels Hospital.*



Mechanizing with MONEL helps make possible...

Savings of 400 Labor Hours a Week

at Queen of Angels Hospital, Los Angeles, California

With a large addition, Queen of Angels Hospital increased its capacity to 502 beds and 103 bassinets.

Then – to keep pace with their expanded requirements – they modernized the laundry department.

A good move, it doubled laundering capacity, with only one third more space. With mechanical handling, linens last longer, so the hospital has been able to reduce its linen inventory.

Laundering supplies are now mechanically measured; washing cycles are automatically timed. Waste is prevented. *Modernization with Monel saved 400 labor hours a week.*

With American's automatic washing control, only 3 simple operations are needed for each load washed. After that, the washer is left unattended until its sterile-clean load is ready for automatic unloading into the extractor container. The unloading takes less than 60 seconds. (The mechanically loaded and unloaded American *Notrux* extractor saves time, too – up to 22 man minutes a load!)

Because this equipment is made of Monel®, linens are safe from damage. Stronger and tougher than structural steel, Monel is *non-rusting*. It resists corrosion by soaps, detergents, alkalis, starches, dilute bleaches and fluoride sours. Washer cylinders and extractor baskets stay smooth, don't develop pits and rough spots.

These, of course, are the same characteristics that make Monel so useful throughout the hospital. **For major types of equipment in clinics, operating and sterilizer rooms, labs, kitchens and cafeterias, there is nothing finer than Monel.** A solid, wear-resistant metal, Monel looks good, stays good year after year. Wherever you use it, you find it pays to insist on Monel – *The Standard Metal of the Modern Hospital.*

START RIGHT NOW!

MECHANIZE with MONEL

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THE INTERNATIONAL NICKEL COMPANY, INC.

67 Wall St., New York 5, N. Y.

why not take this step right NOW to reduce accounting costs?

Everybody talks about cutting costs these days, but it takes positive action—NOW—to realize maximum savings of your hospital's vital dollars!

Greater speed and accuracy—with substantial savings in accounting costs—result from the installation of a National Window-Posting Machine because . . .

In just one rapid operation, it posts the bill, the account card, the journal sheet, and the posting voucher with machine-printed amounts . . . All bills are posted daily, are always in balance, and immediately available on demand . . . All printings are original and identical—no carbons are used.

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Ask your local National representative—a systems analyst—to show you how your costs can be lowered . . . NOW. Or, write to The National Cash Register Company, Dayton 9, Ohio.

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CASH REGISTERS • ADDING MACHINES

THE NATIONAL CASH REGISTER COMPANY

RAW MATERIAL SAVINGS PASSED ON TO YOU!

O-syl prices REDUCED!

More proof—that this outstanding disinfectant value gives *quality* performance at a *quantity* price!

Swift—Sure! Attacks vegetative pathogenic bacteria and fungi. Never fades or discolors floors, walls, bedding furniture.

Pleasant Odor! Unlike many familiar disinfectants, O-syl never leaves any traces of disagreeable odor.

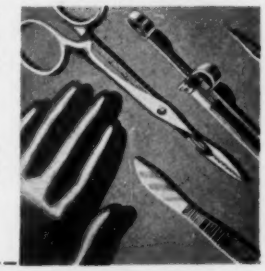
Non-caustic — Non-irritating! Potent—yet never burns as an antiseptic rinse, or as an application on obstetric patients.

Potent—Effective! Completely safe and sure for the disinfection of dishes and utensils used by patients with contagious diseases.

More Economical! Gallon price reduced from $3.00 to $2.70! Diluted 100 times, O-syl makes a potent disinfectant solution for general use—for as little as 2.2¢ per gallon!

Highly concentrated! Even when greatly diluted, O-syl is extremely powerful in its anti-bacterial action.

Non-corrosive! O-syl guards expensive instruments from rust, safely and surely disinfects rubber goods.



Non-Specific! Eliminates the necessity of keeping several germicides for various specific purposes.

FOR SAFETY'S SAKE... the significant new development in disinfectants

10% PRICE REDUCTION! SAME DISCOUNTS!

O-SYL (HOSPITAL STRENGTH, PHENOL COEFFICIENT 5) IS LISTED AT $2.70 PER GALLON (FORMERLY $3.00) IN GLASS CONTAINERS.

5% discount for shipment in individual 5-gal. drums. 10% discount for shipment in individual 10-gal. drums. 20% discount for shipment in individual 50-gal. drums. Freight prepaid on 10 or more gallons shipped at one time to one address. Terms 2% 10 days, 30 days net.

O-syl

Professional sample upon request. Call your hospital supply dealer or write direct to: Lehn and Fink Products Corp., Hospital Dept., 445 Park Ave., New York 22, N. Y.

Looking for Shortcuts?

There's a more practical one you can start using tomorrow—with better results. It is VENOPAK, Abbott's completely disposable venoclysis unit, with Abbott's ampoule-quality solutions. Sterile, pyrogen-free, ready for instant use, VENOPAK obviates the entire time-consuming cycle of assembling, disassembling, washing and sterilizing of ordinary equipment. It also eliminates any possibility of cross reactions. You use VENOPAK once *and throw away.* See a *few* of the advantages of VENOPAK below, then ask your Abbott representative to prove *all* the advantages of VENOPAK with Abbott Intravenous Solutions—or write to HOSPITAL DIVISION, ABBOTT LABORATORIES, North Chicago, Illinois.

1. NO PRE-PREPARATION

VENOPAK comes in a single, easy-to-store package, sterile, ready for instant use.

2. NO ASSEMBLY PROBLEMS

Simply unscrew container cap, screw on VENOPAK dispensing cap. Suspend.

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Following infusion, throw away the entire unit, container and VENOPAK

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CONTINENTALAIR

Sustained temperature with the Continentalair Iceless Oxygen Tent is fully automatic, pre-set by a simple turn of a dial and maintained without further regulation by the attendant. Such finger tip simplified control is characteristic of the Continentalair—it leaves the attendant free for other duties, while the patient is provided with cooled, regulated oxygen with no-draft circulation. If high oxygen concentration is required in an emergency, a special valve permits flooding of the canopy. It's as simple as that.

For thirteen years Continental engineers have been developing features in automatic operation that have provided a simple, effective method of oxygen therapy administration, together with a unit that is economical and dependable. The Continentalair has been accepted by the Council on Physical Medicine, American Medical Association; the Canadian Standards Association; the New York City Code; and approved by Underwriters' Laboratories, Incorporated.

Write for illustrated folder giving detailed information on the exclusive features of the Continentalair Iceless Oxygen Tent. More than 6000 units now in service throughout the world.

CONTINENTAL HOSPITAL SERVICE, Inc. • **18636 DETROIT AVENUE CLEVELAND 7, OHIO**

RED LILY PITTED RED TART CHERRIES

water packed—in number ten tins—are a wonderful means of pepping up the February menu, with cherry tarts or good cherry pie.

Packed in our own Ellsworth, Michigan cannery. Every tin is filled to the brim with luscious, meaty, whole cherries.

If you are not familiar with this fine item, ask your MONARCH man to cut them for you.

MONARCH

World's Largest Family of Nationally Distributed Finer Foods

REID MURDOCH, Division of Consolidated Grocers Corp., Chicago, Ill.

Want Advertisements

POSITIONS WANTED

ADMINISTRATOR—Male, age 37; desires 150 to 200-bed church operated; experience in all phases of hospital administration; now assistant in 350-bed institution. MW 82, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR — Male; with excellent background of experience; would like to serve as hospital administrator, assistant administrator or purchasing agent; has handled public relations, personnel and purchasing. MW 78, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Retired army officer; Fellow, American College Hospital Administrators; administrative experience in civil hospitals; desires position west or south; available now. MW 85, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST — Registered nurse; experienced in nursing supervision and anesthesia; desires position as supervisor of small general hospital; willing to do some anesthesia; registered in Virginia, West Virginia and Maryland; prefers a position in any one of these states. MW 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSING—Or assistant; general hospital; graduate staff; vicinity New York City or Philadelphia area; will consider New Jersey. MW 86, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

HOUSEKEEPER—Trained, Canadian; desires position in fair sized modern hospital; middle-west location; good reference; available about December 1; send full particulars. MW 69, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LAUNDRY MANAGER—former owner, 23 years broad commercial experience; capable executive with business engineering and labor relations background; available in spring. MW 87, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MANAGER — Office; personnel, purchasing, public relations, business and hospital background; small or medium hospital preferred. MW 83, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS — Dietitian; experienced former college professor, home economics; 20 years teacher training and dietitian training; employed as dietitian at present; Pharmacist; retail, 25 years; last war, 3 years; husband and wife desire location together; eastern or New York, New Jersey; small town or city; salary open; full maintenance, apartment; available one months' notice. MW 79, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SECRETARY—Medical dictaphone and autograph recorder; capable and experienced; desires top-flight position with hospital or clinic; also medical records experience; Chicago or Wisconsin area preferred. MW 84, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

DIRECTOR, NURSING SERVICE—B.S. Degree, University of Southern California; 15 years experience, director of nursing, general and tuberculosis sanatoriums; 4 years superintendent, mid-western hospitals.

ADMINISTRATOR—Age, 36 years; 6 years purchasing agent, 185-bed Pennsylvania hospital; 7 years superintendent, 125-bed hospital; available.

ADMINISTRATOR—Age, 35 years; graduate western university; 5 years superintendent, outstanding 100-bed hospital, northwest; desires change.

ASSISTANT ADMINISTRATOR—Degree, Hospital Administration, University of Chicago; executive officer, Army hospitals; 2 years administrative assistant, 300-bed hospital.

PERSONNEL DIRECTOR — Or purchasing agent; Degree, Business Administration; experience as office manager, 250-bed hospital, 5 years.

THE MEDICAL BUREAU

Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR — Medical; A.B., M.D., eastern schools; four years, assistant administrator, large teaching hospital; eight years, director, 350-bed hospital; FACHA.

ADMINISTRATOR — Graduate nurse; B.S., Nursing Education; Master's Degree, Hospital Administration; served successfully as operating room supervisor and director of nurses before specializing in hospital administration; past several years, administrator, 125-bed hospital.

ADMINISTRATOR—A.B., eastern university; M.S., Hospital Administration; year's administrative residency, teaching hospital; three years, assistant administrator, large teaching hospital; four years, administrator, 175-bed hospital; member, ACHA.

ADMINISTRATOR—Assistantship, or directorship, small hospital, preferred; Master's in Hospital Administration; year's administrative residency; two years, assistant, 350-bed hospital.

ANESTHESIOLOGIST—Degrees from eastern schools; teaching hospital internship; several years' general practice before specializing; six years, director of anesthesiology, large teaching hospital.

BACTERIOLOGIST—M.S. bacteriology; year's training, laboratory technique; ASCP; past three years, chief bacteriologist, large hospital.

EXECUTIVE HOUSEKEEPER—Several years, hotel housekeeping director; three years, executive housekeeper, 200-bed hospital.

(Continued on page 194)

MEDICAL BUREAU—*Continued*

PATHOLOGIST—Diplomate; B.S., M.B., M.D., state university; year's teaching internship; three-year fellowship, pathology, university medical center; several years, director, pathology, 250-bed hospital; Fellow, College of American Pathologists, FASCP.

PERSONNEL DIRECTOR—B.S. Business Administration with majors in personnel and industrial relations; past year, personnel director, 125-bed hospital.

PHARMACIST—B.S. in Pharmacy; four years, assistant pharmacist, teaching hospital; now completing two years' graduate training in hospital pharmacy and science for which Master's Degree will be awarded.

RADIOLOGIST — Certified, therapeutic and diagnostic radiology; past several years, radiologist, group clinic; teaching and research experience; prefers directorship, hospital department of radiology.

SOCIAL SERVICE ADMINISTRATOR—M.S. in Social Work, eastern university; seven years' experience in administrative social work.

TECHNICIAN—ASCT, well qualified in bacteriology; B.A., M.A. Degrees; 10 years' experience as laboratory technician; past 3 years, bacteriologist, teaching hospital.

POSITIONS OPEN

ANESTHETIST—Graduate nurse; in a modern well-equipped 200-bed Michigan hospital, located in lake area in close proximity to metropolitan Detroit; five anesthetists on staff; $285 base pay with $10 step increases at 6, 12, 24 and 36 months; excellent cafeteria meals; uniforms laundered. Write Director, Pontiac General Hospital, Pontiac, Michigan.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—Nurse; one; 150-bed hospital; $300 per month and full maintenance; department directed by medical anesthetist; state experience. Apply to Director of Anesthesia, St. Francis Sanitarium, Monroe, Louisiana.

DIETITIAN—Assistant; wanted for 200-bed tuberculosis hospital; good salary plus room, board and laundry; please send small photograph or snapshot with letter of application stating qualifications and pertinent personal details. Apply Superintendent, Indiana State Sanatorium, Rockville, Indiana.

DIETITIAN—Assistant; must be registered; to teach dietetics in 300-bed general hospital with school of nursing. Write, Administrator, Arkansas Baptist Hospital, Little Rock, Arkansas.

DIETITIAN—Pediatric; Raymond Blank Memorial Hospital for Children; 112 beds; childrens' hospital affiliated with Iowa Methodist Hospital; position includes responsibility for formula room and three serving kitchens; new hospital; best of equipment; dietary department of six ADA dietitians; salary open. Write, Chief Dietitian, Iowa Methodist Hospital, Des Moines, Iowa.

Terms: 15c a word—minimum charge of $3.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

Want Advertisements

POSITIONS OPEN

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIANS—477-bed general hospital in New England has two openings: assistant dietitian, preferably ADA member; therapeutic dietitian to supervise floor kitchens and maintain patient contact; full maintenance is available; located within 70 miles of New York City. MO 73, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; for 100-bed hospital; east; college credits required; salary open. MO 64, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR — Science; Degree required; some experience preferred; four weeks' vacation, two weeks' sick leave per year; 40-hour week; salary open; 150-bed hospital. Apply, Director of Nurses, Memorial Hospital, Albany, New York.

LIBRARIAN—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and outpatient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

MISCELLANEOUS — Assistant directors of nursing (psychiatric); one position in charge of nursing service; one position in charge of nursing education; prefer Master's Degree, for nursing service, degree in nursing service administration, some courses in personnel administration and experience in a supervisory capacity in psychiatric hospital; for nursing education, degree in psychiatric nursing, courses in nursing education and experience and clinical instructor in psychintric hospital; salary $352 with provision for increases; 3 weeks vacation; sick leave; good retirement plan. Apply to Bureau of Personnel, State Capitol, Madison, Wisconsin.

MISCELLANEOUS—Nursing arts instructor; Educational director; Operating room supervisor, needed at once; immediate opening; good location; State Capitol with many civic advantages; salary open. Apply Director of Nurses, Evangelical Hospital, 6th and Thayer, Bismarck, North Dakota.

NURSES—Full or part-time assignments; opportunities for progressive experience in general hospital near university; special surgical program; convenient living quarters and food service in residence hall. Address, Director of Nursing, Mount Sinai Hospital, Cleveland, Ohio.

NURSES—Graduate; for general duty; 8-hour day, 48-hour week; salary $145 per month plus full maintenance and income tax; fare refunded after 6 months. Apply, Sister Superior, St. Joseph's Hospital, Barrhead, Alberta.

(Continued on page 196)

NURSES—General staff; for 600-bed general hospital; openings on all services including operating room; salary $140 per month plus complete maintenance; $20 per month extra for permanent 3-11 or 11-7 duty; annual salary increases; 44-hour week; 24 days vacation and 24-day ill time allowance the first year; 6 holidays with pay; opportunity to take courses in nursing education at Duke University. Write, Director of Nursing Service, Duke Hospital, Durham, North Carolina.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margarstville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Registered; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

NURSES—Staff; to work 44-hour week on a rotating shift of two weeks on each shift; permanent afternoons or night shift would be considered; our present rate is $200 per month; this salary also includes a day off for every legal holiday, two weeks paid vacation after a year's service, and six paid sick days after six months service; living quarters are available next to the hospital for $18 per month; a descriptive brochure containing general information about the hospital will be mailed to you. Apply Director of Nursing, Doctors Hospital, 12345 Cedar Road, Cleveland Heights 6, Ohio.

Want Advertisements

POSITIONS OPEN

NURSES—Registered nurses and registered psychiatric nurses; men and women; for state hospital assignments, for general duty, hospital work, tuberculosis and psychiatry; also registered psychiatric nurses with college degree as instructors of affiliating schools of psychiatric nursing; good salaries; opportunity for advancement; excellent retirement and insurance plan. Write, Division of Personnel Service, Department of Public Welfare, State Armory, Springfield, Illinois.

NURSES—Staff; urgently needed for communicable diseases and tuberculosis nursing in large, modern hospital; salary, $1968 per year with increments to $2268; additional allowances of $200 per year for tuberculosis nursing; full maintenance; 44 hours duty per week; 6 legal holidays; paid vacation of 3 weeks per year; accumulative sick leave allowance; generous retirement plan. Apply to Superintendent of Nurses, Philadelphia Hospital for Contagious Diseases, 4000 N. Front Street, Philadelphia 40, Pennsylvania.

NURSE—Staff; for modern 405-bed general hospital located in the heart of Washington; starting salary $2460 per year, with additional compensation for evening and night duty; vacations, holidays, and sick leave privileges; furnished or unfurnished apartments available; dormitory quarters at twenty-five dollars per month. Apply, Director of Nursing, Box H-2, The George Washington University Hospital, 901 23rd Street, Northwest, Washington 7, District of Columbia.

PSYCHIATRISTS—Openings for senior, assistant and junior; for staff or progressive and fully approved state hospital; excellent salary Delaware State Hospital, Farnhurst, Delaware.

RESIDENCIES — Anesthesiology; fully approved; clinical and didactic instruction in all phases of anesthesia; university affiliation. Apply, Administrator, Evanston Hospital, Evanston, Illinois.

RESIDENCY IN PATHOLOGY—One to three year appointment beginning July 1, 1950. Apply, Superintendent, Hurley Hospital, Flint, Michigan.

SUPERVISOR—An interesting opportunity for a qualified nurse to supervise an expanding program in tuberculosis nursing in a large, modern hospital; salary $2604 per year with increments to $2904; full maintenance; 44 hours duty per week; 6 legal holidays; paid vacation of 3 weeks per year; accumulative sick leave allowance; generous retirement plan. Apply to Superintendent of Nurses, Philadelphia Hospital for Contagious Diseases, 4000 N. Front St., Philadelphia 40, Pennsylvania.

SUPERVISOR—Obstetrical; for 238-bed general hospital near New York City; B.S. Degree; supervisory and teaching experience required; excellent facilities; 42 beds 48 bassinets; 30 to 35 nurses on maternity staff; 4 weeks vacation; 2 weeks paid sick leave; 44-hour week. Apply, Director of Nurses, Englewood Hospital, Englewood, New Jersey.

(Continued on page 198)

SUPERVISOR — Associate operating room; teaching ability essential. Write, Director of the School of Nursing, St. Luke's Hospital, Denver, Colorado.

SUPERVISOR—Operating room; for 150-bed general hospital school of nursing; advanced preparation and experience desired; 44-hour week; teaching responsibilities; salary open but commensurate with ability and training. Write, Director of Nurses, Bryan Memorial Hospital, Lincoln, Nebraska.

SUPERVISORS—For medical and surgical nursing, wards; medical and surgical nursing, private; large general hospital; administrative duties only; degree and experience preferred; overall cash salary depends upon qualifications. Apply, Superintendent of Nurses, Cooper Hospital, Camden 3, New Jersey.

SUPERVISORS — Psychiatric, two; position open for day and night duty; private approved 90-bed hospital near Cleveland; salary with complete maintenance; 2 weeks' vacation, 7 holidays, sick leave; state salary expected. Apply Director, Windsor Hospital, Chagrin Falls, Ohio.

THERAPIST—Physical; able to take charge of department in 170-bed hospital near Detroit; maintenance available in nurses' home. Wyandotte General Hospital, Wyandotte, Michigan.

Want Advertisements

POSITIONS OPEN

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
553 South Western Avenue
Los Angeles 5, California

ANESTHETISTS—(a) Catholic hospital, Oregon; $350. (b) County hospital, southern Arizona city; medical anesthetist in charge; $275, maintenance.

ASSISTANT EDUCATIONAL DIRECTOR—For mid-term appointment; one of the large and well-known hospitals in the San Francisco Bay area; salary open.

SUPERINTENDENT OF NURSES—Small general hospital, beautiful Feather River country, northeastern California; must be able to supervise surgery and obstetrics; $315; 40-hour week.

AFTERNOON SUPERVISOR—Teaching hospital, 350-beds, near Los Angeles; $270; 40-hour week, liberal vacation and holidays.

GENERAL DUTY NURSES—For High Sierra locations, California-Nevada line; vacation paradise, hunting, fishing, mountain sports, incomparable scenery; maintenance, $200.

SURGERY NURSES—Two for Texas hospital of 150 beds; $200, maintenance.

BUSINESS AND MEDICAL—*Continued*

OPERATING ROOM SUPERVISOR—County hospital, 350-beds, southern California agricultural section 60 miles from Los Angeles; responsible for two surgeries, supply rooms, seven graduates, six aides, six students; $256; no call; 40-hour week.

OBSTETRICS NURSE—New district hospital near coast and half way between Los Angeles and San Francisco; $225; 40-hour week.

DIETITIANS—(a) Administrative; large teaching hospital, southern California metropolitan area; $275. (b) Private sanatorium near Los Angeles; $250, maintenance. (c) Tuberculosis hospital of 150 beds, southern California mountains; $260.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) R.N.; industrial hospital, 100 beds; east; $4200, maintenance. (b) 50-bed hospital; college town, Ohio. (c) 65-bed hospital; Virginia; expansion program planned. (d) 35-75-bed hospitals; Dakotas, Kansas, Colorado, Montana, Indiana; $225-$300, maintenance.

ADMINISTRATOR—(a) 150-bed hospital; New England; fully approved; near large industrial center; salary $9000. (b) 110-bed hospital; eastern Pennsylvania. (c) 70-bed hospital; Maryland. (d) 80-bed hospital, New York State.

(Continued on page 200)

INTERSTATE—*Continued*

DIRECTOR OF NURSING—(a) Open May; 250-bed hospital, near Baltimore; well stabilized staff; 120 students; excellent salary. (b) New 175-bed hospital; mid-western university city. (c) 125-bed hospital; southern Michigan. (d) 225-bed Ohio hospital; $4,500, maintenance. (e) 250-bed medical center hospital; southwest.

DIRECTOR, NURSING SERVICE—(a) New hospital; 60 beds; Tennessee, Texas, Kansas. (b) 85-bed hospital; southeast. (c) 100-bed hospital; Ohio; graduate staff; $325.

SUPERVISORS—Tuberculosis; 350-bed sanatoriums; west coast, mid-west; teaching responsibilities; excellent salary and living quarters.

SUPERVISORS—(a) Obstetrics; 200-bed hospital; university city, mid-west; $300. (b) Pediatric; eastern hospital; new unit being organized. (c) Operating room; modern surgical suite, in new wing; Ohio; $250, maintenance.

GENERAL DUTY—(a) Small hospital; California; attractive working and living conditions; $225; 40-hour week. (b) Southwestern hospitals; $200, maintenance.

LABORATORY TECHNICIAN—(a) Chief; 125-bed hospital; eastern Pennsylvania. (b) 100-bed hospital; Oregon; $275.

X-RAY TECHNICIAN—(a) 400-bed hospital; east; $4,000. (b) 125-bed hospital; mid-west; $250.

Want Advertisements

POSITIONS OPEN

INTERSTATE—*Continued*

RECORD LIBRARIAN—(a) Private clinic; southern university city. (b) New hospital; Texas. (c) 175-bed hospital, near New York. (d) 415-bed hospital; Ohio.

ANESTHETISTS—(a) $350, maintenance; east, mid-west, south. (b) 350-bed Sisters' hospital; $325.

DIETITIANS—(a) Administrative; 450-bed eastern hospital; $4500. (b) Assistants, administrative; therapeutic. (c) Cafeteria director; $250.

HOUSEKEEPER—(a) Large teaching hospital; east. (b) 300-bed Ohio hospital.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATIVE STAFF APPOINTMENTS—(a) Personnel director to assist executive director and, also, personnel director, hospital and clinic, expansion program; southwest. (b) Admitting officer; young man with minimum year's hospital or hotel training; university hospital; east. (c) Chief accountant; hospital and clinic, middle west. MH2-2.

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—(a) Chief, division of hospitals; new division for inspection and licensure of hospitals; duties include administering Hill-Burton federal aid to hospital program. (b) Medical; associate directorship; university group of hospitals; preferably one with several years' experience directing large hospital. (c) Voluntary hospital, fairly large size; California; preference for man in mid-thirties with approximately 10 years' administrative experience as assistant superintendent or superintendent. (d) Lay; one of country's most famous hospitals, 400 beds; teaching affiliations; university medical center. (e) Lay or medical; voluntary hospital, 200 beds; progressive medical staff; suburb large city, university medical center; east. (f) Lay; preferably one well qualified public relations; 300 beds; college town, 60,000, midwest. (g) Lay; 90-bed rural hospital under construction; advantageous if experienced fund raising, public relations; around $10,000; east. (h) Business manager; young man formally trained in hospital administration to assume business responsibilities of hospital in cooperation with medical director; pediatric hospital, unit of university group. (i) Small general hospital now under construction; completion expected May 1st; preferably one available soon; residential town near university medical center; south. (j) Assistant administrator experienced in hospital purchasing; 250-bed general hospital. (k) Assistant; accounting background desirable; 250-bed hospital; south. (l) Business manager; small hospital and five-man clinic; college town, midsouth. (m) Executive secretary; medical society; public relations or newspaper experience desirable. MH2-1.

(Continued on page 202)

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES—(a) New hospital nearing completion; capacity 70 beds; town of 15,000, midwest. (b) small tuberculosis sanatorium; duties administrative; college town near Chicago. (c) Home for elderly women and orphans; college town, east. (d) Convalescent home for children; outskirts of university center; south. (e) Assistant, qualified to succeed administrator upon retirement; fairly large hospital; midwest. MH2-3.

ANESTHETISTS—(a) Two; large general hospital; town of 125,000, located in beautiful section of eastern state; new dormitory providing private room or apartment; $350, maintenance. (b) Small general hospital; excellent staff; residential town near Houston; $350, maintenance. (c) Modern well equipped hospital operated under American auspices in Venezuela; knowledge of Spanish desirable; around $4400; immediately. MH2-4.

DIETITIANS—(a) Chief; newly equipped department, 175-bed hospital; California. (b) Two assistant dietitians; 450-bed hospital; university town; east. (c) Chief; 250-bed hospital; residential town near Chicago. (d) To take charge of department, new hospital operated by private practice group; $3600-$4800; resort area, southwest. (e) Chief; general hospital recently opened under American auspices in South America; knowledge of Spanish desirable. (f) Supervisors of recipe development and food photography; one of leading food manufacturing companies. (g) Nutritionist; university appointment; duties consist of serving as consultant; middle west.

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

(h) Administrative dietitian and therapeutic dietitian: teaching hospital; university medical center, south. (i) Chief; large general hospital; university town; around $4000, maintenance, midwest. (j) Assistant; San Francisco area. MH2-5.

DIRECTORS OF NURSES—(a) Director of nursing, fairly large hospital; 65 students; town of 60,000 near university center; intermountain area of northwest. (b) Small general hospital operated by famed group; all-graduate staff; building program includes larger hospital; winter resort area of southwest. (c) Assistant; large teaching hospital; preferably one qualified to succeed director upon retirement. (d) One of country's largest teaching hospitals; duties principally administration, public relations; associate directors in charge of school, nursing service; preference for someone with doctorate; $7200, maintenance. (e) General 300-bed hospital; university center, middle west; staff includes two associate directors, one in charge of service; the other in charge of school. (f) Maternity unit of hospital group; experience or special training obstetrics-gynecology desirable; substantial salary including apartment. (g) Director of nursing service; general hospital under construction; all-graduate staff; residential town, middle west. (h) General 300-bed hospital operated by one of country's outstanding private practice groups; woman of outstanding qualifications required; university and college town. (i) Large hospital for nervous and mental diseases; $5000. MH2-6.

EXECUTIVE HOUSEKEEPERS—(a) New hospital, 500 beds; medical school affiliations; east. (b) General 600-bed teaching hospital; university center, middle west. (c) Large general hospital; Pacific Coast. MH2-7.

FACULTY APPOINTMENTS—(a) Instructor in nursing education; advanced clinical course; university faculty appointment; $4200-$5300. (b) Educational director; one of leading voluntary hospitals, middle west; teaching affiliations; university center, $4000. (c) Instructor, psychiatric nursing; new unit, 200 beds; university affiliations; $4800-$5400. (d) Several instructors; large teaching hospital; appointments carrying academic rank of instructors, university faculty. (e) Nursing arts instructor; 100 students; college affiliations; although degree required will consider someone working toward degree; university town, south; $275, maintenance. MH2-8.

MISCELLANEOUS—(a) College nurse; to direct student health department, liberal arts college; Pacific Coast. (b) Admitting nurse; large teaching hospital; middle west. (c) School nurse to take charge of dispensary and direct program in school for boys; near Chicago. MH2-9.

MEDICAL RECORD LIBRARIANS—(a) Chief; one of country's leading teaching hospitals; staff of 26; minimum $4000. (b) General hospital, 175 beds; college town, New England. (c) Chief; fairly large hospital; staff of 30; Pacific Coast. (d) Chief; competent organizer required; one of leading hospitals; Chicago area. MH2-10.

(*Continued on page 204*)

MEDICAL BUREAU—*Continued*

PHARMACISTS—(a) Chief; 300-bed general hospital; university town, south. (b) 250-bed hospital now under construction, teaching and training center; middle west. MH2-11.

STAFF NURSES—(a) Several; industrial hospital, American company; Arabia. (b) New hospital, one of larger towns located on coast of Alaska. (c) Relatively new hospital in Hawaii. MH2-12.

SUPERVISORS—(a) Operating room, night and medical floor; well equipped modern hospital operated under American auspices in Asia. (b) Orthopedic nurse to direct child welfare program; university town, northwest; $4200-$4800. (c) Medical; one of Florida's leading hospitals; winter resort city. (d) Obstetrical; teaching hospital; 600 beds; outstanding opportunity; minimum $3600. (e) Pediatric; general hospital, 500 beds; city having two universities, several colleges; $360. (f) Operating room, fairly large hospital, general; large city, port of entry, short distance from New York; $4200. MH2-13.

TECHNICIANS—(a) Young man to serve as assistant laboratory director; fairly large hospital; chemistry background desirable; $5000-$7000. (b) Graduate nurse qualified x-ray; duties include supervising; new hospital, South America; $5100. (c) Recreational director; large teaching hospital; east. (d) Chief occupational therapist; large general hospital; staff of six therapists; $4600. (e) Chief technician; staff of six technicians; 200-bed hospital; medical center; west. (f) X-ray and laboratory technician; relatively new hospital, Alaska. (g) Physical therapy; new department, 400-bed hospital; university town, midwest. MH2-14.

Want Advertisements

POSITIONS OPEN

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OFFICE MANAGER ACCOUNTANT—155-bed hospital; eastern Pennsylvania.

ANESTHETISTS—(a) 100-bed; $3900. (b) 54-bed new hospital; $3000; maintenance.

DIRECTOR OF NURSES—275-bed; $3900; maintenance includes a 3-room and bath apartment.

DIETITIAN—Head; small new general hospital; $3000, maintenance.

RECORD LIBRARIANS—(a) Chief; 350-bed hospital. (b) 60-bed; middle-aged woman preferred; $300.

PHYSIOTHERAPIST—Head; new department; resort city; starting $300.

PHARMACISTS—(a) 100-bed; $2400, complete maintenance. (b) 200-bed; New York; starting $300; partial maintenance.

TECHNICIANS—(a) X-ray chief; new radiology department. (b) Laboratory; chief and assistant; 130-bed; salary high; maintenance.

MEDICAL PERSONNEL EXCHANGE
—Continued

EXECUTIVE HOUSEKEEPERS—(a) 550-bed, university hospital. (b) 120-bed, New York; $2100, maintenance.

SOCIAL SERVICE—(a) Director; 275-bed general hospital; $3600, plus maintenance, including apartment. (b) Staff; starting $2800.

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SUPERINTENDENT OF NURSES—New York; preferably Master's Degree; $4500 plus apartment.

PERSONNEL DIRECTOR—Combined with purchasing; hospital, New England; salary open.

DIETITIANS—Assistants; Degrees, ADA; east; salaries open.

ANESTHETIST—Lovely job; beautiful suburban hospital, Westchester; prevailing salary.

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ADMINISTRATOR—West; 120-bed hospital located in beautiful scenic country noted for its mountain drives and resorts; winters are mild and summers warm with balmy mountain breezes and cool nights; modern nurses home with classrooms and dormitory; also a graduate nurses home; there is no financial problem for the new administrator and he will be ably assisted by an administrative assistant who has an extensive knowledge of the operation of the hospital; medical staff is exceptionally fine; must have good background in accounting and public relations and a minimum of five years experience in hospital administration.

CREDIT MANAGER—Clinic, middlewest; group of 12 physicians, mostly all certified; own the clinic building; town of 40,000 ideally located, easily accessible to larger cities.

ASSISTANT ADMINISTRATOR—R.N.: middlewest; 100-bed hospital ideally located in beautiful residential section in city of 50,000; good transportation to several larger cities.

EXECUTIVE HOUSEKEEPER—Teaching institution; one of south's leading hospitals; must be well trained, experienced and efficient; this is an unusual opportunity.

EXECUTIVE HOUSEKEEPER—Middlewest; 600-bed teaching hospital completely new; will be ready for operation in near future; want housekeeper now to help set up systems, etc.; should have extensive experience in administrative capacity.

(Continued on page 206)

Want Advertisements

POSITIONS OPEN

SHAY—*Continued*

DIETITIANS—(a) Assistant to chief; east; ADA or eligible; overall supervision of dietary department in absence of chief dietitian; $250, maintenance. (b) Floor; east; 400-bed hospital fully approved; make regular patient visits and medical staff contacts; also supervise various floor kitchens; $200, maintenance. (c) Chief; middlewest; 110-bed hospital; city of 20,000; $300, maintenance. (d) Administrative assistant; northeast; knowledge of therapeutic and clinical work plus some administrative experience; will have charge of main kitchen and cafeteria; $300, maintenance.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATORS—(a) Lay; large general voluntary hospital with extensive plans for future development; west coast; $12,000. (b) Lay; 200-bed voluntary hospital; excellent administrative and medical staffs; fairly large nursing school; requires individual under 40 with about ten years hospital administrative experience; California; about $9000. (c) Medical; large clinic of 15 man group affiliated

WOODWARD—*Continued*

large southern refinery; mature physician not over 45; university city 40,000; about $9000. (d) Lay; fairly large general; about $8500 plus lovely furnished home well situated on hospital grounds; New England. (e) Medical-assistant; 400-bed general; very large visiting medical staff; well developed residency program; eastern metropolitan area; about $7500. (f) Lay; 50-bed general to open within several months; preferably well qualified and having hospital administrative residency; about $6000; central. (g) Lay; smaller hospital constructing $600,000 addition; eastern seaboard city; about $5000. (h) Medical-assistant; large eastern general; $5000 for individual with hospital experience; less for apprentice with excellent advancement. (i) Medical assistant; well staffed 400-bed voluntary general hospital; south. (j) Lay; 250-bed voluntary hospital; desirable university city 60,000; central. (k) Lay; exceptional opportunity to develop entire program of four integrated smaller hospitals; northeast. (l) Lay; medium size Pacific northwest voluntary general; excellent faculty; desirable university city. (m) Lay; medium size general; fairly large nurses training school; Pennsylvania. (n) Medical; 400-bed general; excellent southeast Atlantic port; winter resort area. (o) Medical director and, also superintendent; Canadian hospital with expansion program under way. (p) Medical; fairly large general in Chicago area; prefer middle-age physician with good administrative experience.

ADMINISTRATORS—Nurse; (a) Assistant; smaller voluntary well staffed general; lovely cultural, educational southern town 15,000. (b) Small new hospital now under construction in exceptionally desirable little town; immediate appointment; central.

(Continued on page 208)

WOODWARD—*Continued*

ADMINISTRATIVE STAFF APPOINTMENTS—(a) Personnel director; 300-bed voluntary general hospital; prefer middle aged person with hospital personnel experience; about $7600; south. (b) Credit manager exceptionally successful 10-man group; well staffed, beautifully equipped building in lovely residential section of industrial city 50,000; central.

ANESTHETISTS—(a) Hawaiian hospital of fairly large bed capacity; well located to all interesting points; $300 minimum; more for superior person. (b) Supervise department of small well equipped industrial hospital; $375; west. (c) Medium size general hospital; completely air-conditioned operating suite; beautiful scenic area near Philadelphia; $350, complete maintenance. (d) Smaller hospital situated on campus large university; southern winter resort city; pleasant private room; $350. (e) Excellent 75-bed children's hospital; also act as superintendent of nurses; will increase to 200 beds eventually; Florida. (f) Large hospital in Chicago area; $310. (g) Large midwest tuberculosis hospital; $350. (h) Well staffed department of 200-bed Iowa voluntary general hospital; about $400. (i) Community health center; work with two surgeons; light operating room duties; excellent for nurse anesthetist interested in technics of medical investigation; about $325; Minnesota. (j) Well staffed operating suite of 150-bed general hospital; Nebraska; $400 for one exceptionally qualified. (k) 300-bed general hospital in very desirable Ohio city, 50,000; $350.

Want Advertisements

POSITIONS OPEN

WOODWARD—*Continued*

DIETITIANS—(a) 100-bed special hospital for convalescent children; responsible for food purchases and meal planning; large university city; east central; about $300. (b) Chief; fairly large college affiliated hospital situated one hour from Chicago; excellent salary for superior person. (c) Chief; fairly new voluntary general hospital; has one of the most modern departments in the state; excellent financial condition; lovely southern town, 15,000. (d) ADA; important tuberculosis hospital increasing soon to 250 beds; $300; full maintenance; Ohio. (e) Chief; ADA; large hospital near New York City; exceptional opportunity and they wish to negotiate salary which will be attractive to top level person. (f) Situated in the western plains section, this very large mental hospital seeks a well qualified individual; no training school; $330. (g) Chief; well staffed department 220-bed general, situated attractive university city, 100,000; fully approved; they will meet financial requirements of superior individual; central. (h) World famous southwest health center; fairly large hospital with very desirable nurses quarters; $300. (i) ADA; 125-bed general, Wisconsin city, 25,000. (j) Well qualified dietitian interested therapeutic dietetics rather than administration; teach diet therapy and nutrition; fairly large Idaho general.

WOODWARD—*Continued*

DIRECTOR OF NURSES—(a) Smaller Kansas voluntary general hospital; excellent city, 10,000; to $4000. (b) One of the most modern schools of nursing in the middle-west; affiliated with large hospital; three nationally recognized universities in this attractive educational city; nurses residence considered one of the country's finest; $4200. (c) 200-bed specialty hospital limiting services to obstetrics, gynecology; eastern metropolitan area; $4500 plus furnished apartment. (d) 300-bed general hospital; 50 full time graduate staff nurses; 70 student nurses in training; large home provides excellent living quarters for the director of nursing; salary will include full maintenance; Utah.

SUPERVISORS—Medical-surgical: (a) 230-bed eastern general near New York City; department of about 80 beds; faculty appointment; about $3240. (b) Public health; P.H. Degree required; Michigan Public Health Department; large staff; $3440 plus traveling expenses.

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(Continued on page 210)

PLACEMENT BUREAUS—*Continued*

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Want Advertisements

PLACEMENT BUREAUS—*Continued*

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Due to the ill health of its Director it has become necessary to sell the BUREAU. It is our hope that someone with a knowledge of the Fields which the BUREAU has served and a recognition of the potentialities of an ethically conducted Executive Consultant and Placement Service may wish to carry it on. All communications will be treated as Confidential. Write C. M. Powell, Owner and Director, American Hospital Bureau, 705 Carnegie Hall, Cleveland 15, Ohio.

STERILIZER — Gas heating unit attached. Manufactured by American Sterilizer Company. 18" x 36". Excellent condition. $200. Tanner Memorial Hospital, Carrollton, Georgia.

(*Continued on page 212*)

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36" x 60"
Gatch Spring

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No. 2506, 30" x 54"
No. 2507, 26" x 42"
"Adjus-tilt" Spring

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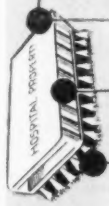

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Want Advertisements

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MERCY COLLEGE SCHOOL OF ANESTHESIA

Offers a twelve-month course in Anesthesiology to graduates of accredited Schools of Nursing. The course includes didactic and clinical experience in all inhalation, intravenous and rectal anesthetics; and in the therapeutic gases: helium, oxygen and carbon dioxide. Classes are admitted the first of January and September. Apply to Director, Department of Anesthesia, Mount Carmel Mercy Hospital, 6071 West Outer Drive, Detroit 21, Michigan.

SCHOOLS—SPECIAL INSTRUCTION

ST. FRANCIS HOSPITAL, Peoria, Illinois, offers a comprehensive course in Anesthesia to graduate nurses of accredited schools of nursing, and is open to Sisters. This course includes all types and methods of Anesthesia in use today. For further information write to Sister M. Borromea, R.N., Director, School of Anesthesiology, St. Francis Hospital, Peoria, Illinois.

The RESEARCH and EDUCATIONAL HOSPITALS OF THE UNIVERSITY OF ILLINOIS offer a four months Clinical Course in Orthopedic Nursing to graduate registered nurses. The course provides closely correlated theory and supervised clinical experience in the nursing care of children and adults with orthopedic conditions. Classes enrolled January, May and September. For further information, address Director of Nursing, Research and Educational Hospitals, 1819 West Polk Street, Chicago 12, Illinois.

JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

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Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

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Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

(Continued on page 214)

Want Advertisements

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

HERRICK MEMORIAL HOSPITAL offers the following programs in the Herrick School of Hospital Arts: 12-month course for Medical Record Librarians; 24-month course for x-ray technicians; 12-month course for practical nurses. Courses G.I. approved or approval pending. For further information, apply to the Director, Herrick School of Hospital Arts, 2001 Dwight Way, Berkeley, California.

QUEEN OF ANGELS HOSPITAL, Los Angeles, California, offers a six-month course for graduate nurses in obstetrics. Classes admitted January 15 and July 15. For further information apply to the Director of Nursing, 2301 Bellevue, Los Angeles 26, California.

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What's New for Hospitals

FEBRUARY 1950 Edited by BESSIE COVERT

Aloe Precision Incubator

Developed under the supervision of the Washington University Department of Pediatrics at the St. Louis Maternity Hospital, the Aloe Precision Infant Incubator is, according to the manufacturer, fully approved by The Underwriters' Laboratories, Inc., for use with oxygen. It is designed for the care of premature infants but its extra large size permits the treatment of larger infants.

The incubator features uniform temperature throughout with temperature-humidiguide on top for easy reading. Extremely high humidity is obtainable when desired and all critical controls are mounted on a luminescent, colored plastic panel with plainly labeled signals and control devices. The frame work is made of welded, rust-resistant sheet steel with chrome-plated fittings. Full visibility is provided by large safety glass panels at front and top and the electrical heating system consists of a fully protected heating element. The bassinet basket is of perforated aluminum and the fiberglas mattress is fireproof, odor-proof, non-allergenic, vermin-proof, soft, resilient, durable and can be sterilized in an autoclave. **A. S. Aloe Co., Dept. MH, 1831 Olive St., St. Louis 3, Mo. (Key No. 175)**

Freezers

A new 26 cubic foot freezer with 900 pounds of frozen storage capacity has recently been introduced by Frigidaire. Constructed of heavy gauge steel with welded seams, the new freezer is finished in glossy, white enamel inside and out and is insulated with fibrous glass on walls and bottom of the storage and freezing compartments. The reciprocating type refrigerating unit has wrap-around refrigerant coils which are fastened to the outside of the compartment walls. The freezing compartment has a special coiling arrangement to speed up freezing and the storage compartment is automatically maintained at constant low temperature.

An independently-powered alarm bell sounds when the cabinet temperature rises 5 or 10 degrees. The unit has removable divider racks, and is equipped with adjustable latches which may be padlocked. **Frigidaire Div., General Motors Corp., Dept. MH, Dayton 1, Ohio. (Key No. 176)**

Adhesive Containers

The Hospital Rack Roll Adhesive Containers developed by Johnson & Johnson are now available completely sealed at top and bottom to prevent tops from falling off and tape becoming dirty and dented. The lid is easily removed after pulling a cutting string. **Johnson & Johnson, Dept. MH, New Brunswick, N.J. (Key No. 177)**

Bouncing Putty

A new product of interest for physical therapy has been developed by General Electric and is known as G-E Silicone Bouncing Putty. The product can be used to exercise muscles of fingers, hands and arms in cases of muscular disability resulting from polio, arthritis, broken bones, long illness or other causes. It is manipulated with enough resistance to provide the needed exercise.

Bouncing Putty is an organosilicon product which will not stick to the hands or leave any odor, does not dry out or change its viscosity, will not stick to non-porous polished surfaces and is not inflammable. Rolled into a ball, Bouncing Putty will bounce faster and higher than an average natural rubber ball when thrown against a hard surface. It disintegrates in water and organic solvents but will flow even at refrigerator temperatures. The product is distributed by **S. R. Gittens, Dept. MH, 1620 Callowhill St., Philadelphia 30, Pa. (Key No. 178)**

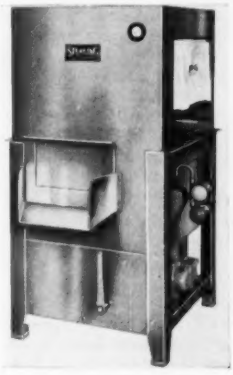
Wall Valve for Oxygen

Protection against leakage is the claim of the manufacturer in announcing the new Ohio Oxygen Pipeline Wall Outlet Valve for installation in patients' rooms where a central oxygen piping system is used. Improved neoprene packing and seat, a hexagonal closing knob for sure, easy sealing and a dust cap with nylon seat are features of the new valve. It can be made tamperproof if desired. **Ohio Chemical & Mfg. Co., Dept. MH, 1400 E. Washington St., Madison 10, Wis. (Key No. 179)**

Toledo Sterling Hydro-Scrap

The new Toledo Sterling Hydro-Scrap is a predishwashing machine that removes unconsumed food from dishes, silver and other table service by a concentrated force of flushing water. It offers a more sanitary method of preliminary dish cleaning while reducing dish breakage, and can be installed with practically any standard machine.

The Hydro-Scrap utilizes the hot water that overflows from the dishwasher, thus being economical to operate. When installed in the dish table near the entrance end of the dishwasher, properly racked soiled dishes are pushed into the machine where they remain until moved forward into the dishwasher by a following rack of dishes. Refuse is quickly cleaned from the unit and separator screen and wash



tubes are removable for cleaning without the use of tools. **Toledo Scale Co., Dept. MH, Toledo 12, Ohio. (Key No. 180)**

Address manufacturers for further information and prices — or use Readers' Service blank on page 224

Respir-Aid Bed

The new, improved model of the Respir-Aid Bed is now in production. Designed for use by patients who need assistance in breathing but who do not need constant confinement in a respirator, the bed has a rocking motion causing the viscera to press against the diaphragm to expel air and to pull air into the lungs as the viscera fall back and the diaphragm is pulled down. Angles of oscillation can be changed on the new model as well as the speed of motion so that the bed can be adjusted for the patient's needs. The two variables are controlled by thymotrol half-wave drives.

The unit consists of a standard Simmons hospital bed frame of the two-crank type mounted by means of rockers on a substantial base which contains the power unit. This is connected by an electrical cable to the control cabinet. The bed frame is provided with removable adjustable side rail guards and a removable mattress rail at the foot. The base is of extra heavy all-steel construction and the axis of oscillation is so placed as to minimize the possibility of sea sickness in susceptible patients. **McKesson Appliance Co., Dept. MH, 2226 Ashland Ave., Toledo 10, Ohio. (Key No. 181)**

"Jacknife" Troffer

The new Guth "Jacknife" Troffer opens and swings down easily for changing lamps and starters right from the floor. The entire reflector assembly can be lifted down for thorough cleaning or repair. Installation of the new troffer has been simplified with the lightweight channels easily mounted in the ceiling and reflector assemblies added from the floor. **The Edwin F. Guth Co., Dept. MH, 2615 Washington Ave., St. Louis 3, Mo. (Key No. 182)**

Stencil Sheets

A complete new line of stencil sheets has recently been announced. Ten types of stencil sheets, ranging from 4 by 8½ inches to 12½ by 22 inches in size, are included, 3 in blue, 5 in yellow and 2 in the new eye-ease green. Both the blue and yellow in legal and letter sizes may be obtained with the new satin finish, low glare film cover. A special white, coated cushion is provided for use with the blue stencils and a black, tissue cushion is provided for the yellow and green. Both types of cushion are designed to provide a high degree of visibility for typing and proof reading. The stencils make possible low cost reproduction of as few as 5 or 6 copies as well as hundreds or thousands of copies. **A. B. Dick Co., Dept. MH, 5700 W. Touhy Ave., Chicago 31. (Key No. 183)**

Portable Polisher

Rehabilitation and maintenance of furniture, wood floors and woodwork will be facilitated with the new Model DF Detroit Easy Finisher. This new portable machine has smooth, vibrationless operation in straight-line sanding, rubbing and polishing. A new streamlined rear handle provides for one hand operation and an instantly attached front guide handle is furnished with each machine for use on overhead and other

work where two hand operation is more comfortable. A new, simple abrasive paper holder permits attaching several sheets at one loading. **Detroit Surfacing Machine Co., Dept. MH, 7433 W. Davison, Detroit 4, Mich. (Key No. 184)**

Louvered Lighting Fixtures

New, all-steel louvered fluorescent lighting fixtures are now available for two 40 watt T12 lamps. Light distribution of 40 per cent upward and 60 per cent downward gives balanced illumination in critical working zones. The louvers are held on both sides by sturdy loop clips which act as hinges and catches so that the louvers may be quickly and easily opened from either side. A special tension arrangement holds the cross louvers in position. The wiring trough cover is hinged for easy accessibility to ballasts, wiring and sockets. Known as Linolite Series 27, the new fixtures can be installed singly or in continuous rows. **The Frink Corp., Dept. MH, 27-01 Bridge Plaza No., Long Island City 1, N.Y. (Key No. 185)**

Standardized Needle Line

A comprehensive needle standardization program begun by Ethicon several years ago has resulted in four new surgical needles designed to take the place of 30 surgical needles currently in common use. These new Ethicon General Closure Needles were developed to meet the increased surgical demand for sutures with needles already attached, to provide needles with strength without excessive thickness, rigidity without brittleness and with optimum handling qualities, and to provide these needles for surgical specialization in types and sizes preferred by surgeons.

The new needles are designed for minimal tissue trauma, greater needle strength, increased holding power, maximum grasping area, no turning in holder, uniform sharpness and long taper. A chart has been developed by the company to indicate which needles are replaced by each of the four new Ethicon General Closure Needles. **Ethicon Suture Laboratories, Dept. MH, New Brunswick, N. J. (Key No. 186)**

Revolving Bins

Of particular interest for use in the storeroom are the new revolving bins recently announced. These are complete storage units, each shelf with a continuous label holder, and are available in 7 shelf unit, 4 shelf unit and counter top revolving bins. Up to 5 additional dividers can be added to separate each bin into smaller openings and wide spacing on the 2 bottom shelves allows for full visibility. The bins are designed to save time and steps, speed up service and increase availability of stored parts. They revolve easily in either direction, are stabilized to prevent sagging and are fin-

ished in green baked-on enamel. **Lyon Metal Products, Incorporated, Dept. MH, Aurora, Ill. (Key No. 187)**

Address manufacturers for further information and prices — or use Readers' Service blank on page 224

Vinyl-Cork Flooring

Dodge Vinyl-Cork Tile is a new flooring which offers many outstanding qualities. Its cork base makes it quiet, comfortable, resilient and serves as an insulation against heat and cold. Its vinyl top is non-slip, wet or dry, provides unusually long wear, does not harden with age, is fire resistant, scratch and abrasion resistant and is easily maintained, it being necessary only to wash with soap and water, no wax being needed.

The flooring is water repellent and is available in 22 different solid color and marbelized combinations which do not fade or discolor. No special adhesives are required for laying the flooring which is easy to handle and does not crack, chip or break when being laid. It is available in standard size squares, 6, 9, and 12 inch and in ⅛, 3/16 and ¼ inch thicknesses with border strip material up to 36 inches in length. **Dodge Cork Company, Inc., Dept. MH, Lancaster, Pa. (Key No. 188)**

Electric Potato Peeler

The Peelmaster Electric Potato Peeler has been redesigned with a new 1 piece aluminum interior which serves as a peeling pot and washing sink. The new interior is so constructed as to allow easy drainage of peelings and water and the machine has working capacity increased to 20 pounds. The table height peeler has a new, smoother peeling disc, carries the Underwriters' label and sells at the same price as the earlier model. **Service Appliance Corp., Dept. MH, 1775 Broadway, New York 19. (Key No. 189)**

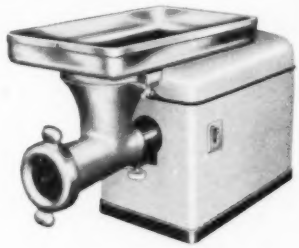
Tube-Ice Package Unit

Designed to manufacture 2000 pounds of "cylinder" or crushed ice in 24 hours, the new Tube-Ice Package Unit contains a 3 h.p. water cooled condensing unit and has an insulated stainless steel lined ice bin which will hold approximately 650 pounds of ice in storage. All operations of the machine are automatic, including shut-off when the storage bin is full. A reversible cutter permits the making of ice in the form of cylinders or crushed.

The ice bin can be opened at the top for removing small quantities of ice but if larger quantities are needed, both doors can be opened for greater access to the ice. **Henry Vogt Machine Co., Dept. MH, 10th & Ormsby Sts., Louisville 10, Ky. (Key No. 190)**

Food Chopper

The new Blakeslee food and meat chopper has quick cutting action which makes a clean cut without crushing or mashing meat and other foods. An extra safety factor for severe overloading, such as bones blocking the knives, is offered in the Vee belt employed on the first speed reduction. The machine is available in 3 sizes to grind from 8 to 30



pounds per minute and an attachment is available with slicer, shredder, julienne and grater plates. All models are available in Duco finish or in stainless steel. **G. S. Blakeslee & Co., Dept. MH, 1844 S. 52nd, Chicago 50. (Key No. 191)**

Miniature Fluorescent Fixture

The Stocker & Yale Model 10 miniature fluorescent lighting fixture is designed to provide an intense but cool and glare-free illumination on small areas. A wide choice of support arm lengths and arrangements is offered to make installation simple yet allow complete adjustment in all directions. The design produces a light intensity of 550 foot-candles at a 3 inch working distance. Fixtures are equipped with 2 lamps producing white light although other colors are available.

The fixtures are sturdily constructed for long and severe use and are finished in light gray baked enamel on outer surfaces with baked white enamel reflector. They operate on 115, 220 and 110 volts DC. **Stocker & Yale, Dept. MH, Marblehead, Mass. (Key No. 192)**

Signaling System

"Chime-Matic" signaling is the name given to the new audio-visual signaling which is now a part of all new Executone fully-intercommunicating stations. It is designed to simplify and speed call-origination. A modulated chime and signal light announces the call automatically at the selected station when any button is pressed. The system is fast and efficient and helps reduce operating costs.

The new electronic voice circuits in the new system are engineered for greater clarity. The line is housed in streamlined cabinets, constructed for long wear and designed to harmonize with any interior decoration. **Executone, Inc., Dept. MH, 415 Lexington Ave., New York 17. (Key No. 193)**

Snow Thrower

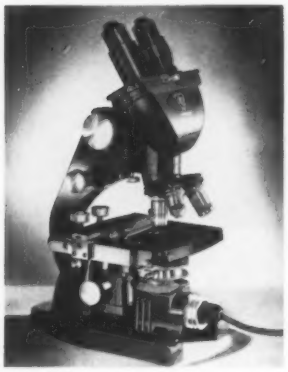
A hand operated, self propelled, rotary snow plow, similar in idea to the large, commercial rotary snow plows, is now available for cleaning walks, drives and grounds. It leaves no built up banks as snow is thrown for some distance and spreads out rather than accumulating in a pile. Known as the Maxim Snow Thrower, the device requires little effort to operate except to follow and guide the machine which will clear snow easily and quickly. It is powered by a 7.2 h.p. air-cooled engine which starts easily even in cold weather. The machine takes little storage space. **The Maxim Silencer Co., Dept. MH, 85 Homestead Ave., Hartford, Conn. (Key No. 194)**

Automatic Ice Maker

The new "X" line of automatic ice cube makers is now going into production. The X-10 features front delivery of ice into an insulated, stainless steel storage cabinet which is detachable and can be rolled away to any dispensing point while another takes its place. The unit automatically shuts off when the storage cabinet is filled and produces approximately 400 pounds or 7360 solid, standard sized cubes daily. Other models in the X line will make from 5440 to 14,720 cubes every 24 hours depending upon size. **The Ice-Flo Corp., Dept. MH, Lonsdale, R.I. (Key No. 195)**

Address manufacturers for further information and prices — or use Readers' Service blank on page 224

AO Spencer Microscopes



A new series of microscopes has been announced which incorporate many new features and refinements. The pilot models have been subjected to hard wear and actual use in a testing procedure to ensure precision operation. The new stand is made of aluminum to reduce weight while giving increased strength and rigidity. A new attached illuminator which provides permanently adjusted illumination that fills the field of all objectives without refocusing the condenser is optional equipment with the AO Spencer Microscopes.

The fork-type substage is larger, sturdier and has new locking and keying devices to assure quick, positive positioning of the condenser. Other features include a new tension adjustment; two knobs, one for each hand, for all controls; ball-bearing ways; spring loading; a new "pinch grip" mechanical stage; a new 10X divisible objective; new dustproof, dust shedding nosepiece, and dual-cone construction for longer life and correct alignment of objectives. **American Optical Co., Scientific Instrument Div., Dept. MH, Buffalo 15, N. Y. (Key No. 196)**

Square Air Diffuser

A new square air diffuser (Type E) that aspirates and distributes air equally and draftlessly over the full arc of 360 degrees has been developed to harmonize with rectangular and straight-line architectural designs. It is flush with the ceiling and fits into standard sized acoustical and egg-crate ceilings. It can be combined with all types of lighting fixtures and is available in 9 different neck diameters ranging from 4 to 14 inches. The diffuser is designed to give complete air distribution throughout an entire room without drafts or stale air pockets. It can be installed quickly and easily. **Anemostat Corporation of America, Dept. MH, 10 E. 39th St., New York 16. (Key No. 197)**

Venous Pressure Instrument

The Phlebaumanometer is a new instrument for measuring venous pressure. It is a gravity instrument designed to determine the blood pressure in large and small veins accurately, quickly and without loss of blood. When operated according to instructions, the instrument shows the venous pressure directly on a graduated scale. The instrument can be operated by one person and it is designed to provide a simple, safe and accurate method of evaluating venous pressure. **The W. A. Baum Co., Inc., Dept. MH, 460 W. 34th St., New York 1. (Key No. 198)**

Lather Type Dispenser

A simplified dispensing mechanism is the feature of the new Bobrick 44 lather type liquid soap dispenser. Made of polished stainless steel with a shatterproof, translucent Luxtrex container that permits the soap level to be observed at all times, the dispenser is designed to give long, trouble-free service. The dispensing mechanism consists of a stainless steel piston, located above the soap level, which eliminates leaking and dripping. Only one spring is used in the valve and the mechanism is completely demountable and replaceable. The steel wall fastening is concealed and through the use of WallPlad, the dispenser can be attached to hard surface walls with or without screws. **Bobrick Mfg. Corp., Dept. MH, 1829 Blake Ave., Los Angeles 26, Calif. (Key No. 199)**

Adhesive Remover

Tapeaway is the name of a new product designed to remove adhesive tape from the skin in a quick, safe and painless manner. It is based on a new principle combining a solvent with a wetting agent in a pressure-spray unit self-dispensed from its container. Tapeaway is pressure-sprayed evenly over the back of the tape surface and after an interval of 30 seconds, adhesive can be lifted off without pain. It is non-irritating and non-toxic to the skin and leaves no sticky residue. **Carand Corp., Dept. MH, Racine, Wis. (Key No. 200)**

Wall Type Convector

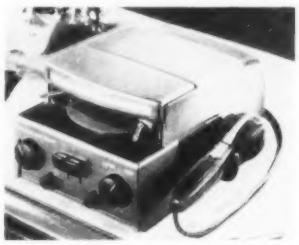
A new low height, high heating capacity, sloping top, wall type convector has recently been announced by the C. A. Dunham Company. Designed for single or multiple installation, a sheet metal "splice plate" conceals the pipe connections between units, giving the appearance of one long continuous convector when installed in a series.

The cabinet has a removable front, horizontally slotted outlet grille and the unit is available with a choice of 3 types of 1¼ inch finned pipe heating elements: steel pipe with steel fins; steel pipe with aluminum fins, or copper pipe with aluminum fins. The convector is 10⅜ inches high and 5½ inches wide, in lengths from 2 to 6 feet in 6 inch increments. It may be used on either steam or forced circulated hot water installations. **C. A. Dunham Co., Dept. MH, 400 W. Madison St., Chicago 6. (Key No. 201)**

1950 Model SoundScriber

Streamlined styling of die-cast metals in an attractive design is a feature of the new 1950 Model SoundScriber. Occupying less desk space than earlier models, the new unit is light in weight but structurally strong. Both recorder and transcriber are available in the new model which is finished in gray enamel.

New developments in electronics and sound reproduction are incorporated in the new model which is completely interchangeable with all existing SoundScriber equipment. One new feature of the unit is the hand microphone which permits the user to listen back to the last few words of dictation by merely pressing a switch. There is no manipulating of the recording instrument itself. Other features include the direct gear-driven, hard-surface turntable and separate recording and reproducing arms, modern styling, light weight, and simplicity of operation for both dictator and transcriber. A feature of the transcriber is an optical system which provides a unique indexing system which eliminates slips and strips commonly used. **SoundScriber Corp., Dept. MH, 146 Munson Ave., New Haven 4, Conn. (Key No. 202)**



Address manufacturers for further information and prices — or use Readers' Service blank on page 224

Stainless Steel Safety Pin

The tensile strength of stainless steel permits the new stainless steel safety pin to be made from wire of narrower diameter, thus permitting sharper point and easier piercing, with the same comparative strength of other pins. Its hardness permits smoother polished points and the pin is made with a wide spring opening to hold firmly when fastened. The pin is non-corrosive and is highly resistant to iodine and similar products and to high temperature autoclaving. **Debs Hospital Supplies, Inc., Dept. MH, 118 S. Clinton St., Chicago 6. (Key No. 203)**

Fabric Designs

New designs, colors and textures in modern, traditional, conventional and documentary patterns are being offered in the extensive new line of Goodall fabrics. Included in the line are 24 new patterns in 225 colors. The materials are easily laundered and color-fast. They resist wrinkles and soil and are designed for long wear. The bright, cheerful patterns and colors are designed for bedspreads, draperies, upholstering and other uses. "Blended" of selected, non-fuzzy, lint-free fibers, the fabrics wash easily with soap and water, resist perspiration, alcohol and most acids, and are available in a wide variety of textures. **Goodall Fabrics, Inc., Dept MH, 525 Madison Ave., New York 22. (Key No. 204)**

Folding Wheel Chair

Several new features are available in the newly designed Boulevard folding wheel chair. It is more comfortable, stronger and provides better shock absorption and smoother riding through the use of double tubular steel cross braces. The new individual aluminum die-cast foot rests are adjusted independently. Known as the 906, the new chair may be equipped with the new Gendron

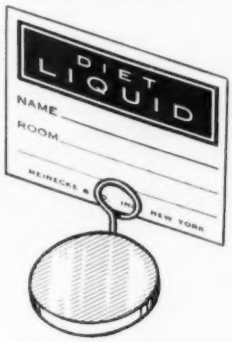
wheel chair lock.

When opened, the new chair has a full 18 inch seat width with seat and back of green Versilan leather. Driving wheels are 24 inches in diameter and equipped with handrims for self-propulsion. The chair has 1 inch rubber tires and 5 inch front free-swiveling casters. It folds to a compact width for easy storage or transportation. **Gendron Wheel Co., Dept. MH, Perrysburg, Ohio. (Key No. 205)**

Medicine Cup

The new Medicine Dixie is an attractive single use medicine cup, available in 1 and 3 ounce sizes. The new paper cup bears graduations showing ounces, teaspoons, tablespoons and cubic centimeters and can be marked on the clock face portion of its design to indicate the time when the portion should be administered. The cup is printed in a pleasing shade of green. **Dixie Cup Co., Dept. MH, Easton, Pa. (Key No. 206)**

Tray Card Holders



To dress up patients' trays, Tray Card Holders are now available in bright colors to match the required diet card. Made with a weighted metal base and finished in heavy enamel, each Tray Card Holder is equipped with a plated spring-steel clip which firmly holds the diet card. Colored diet cards are now available in 9 standard colors for various special diet requirements, 3 new ones covering Salt Free, Ulcer and High Protein diets having recently been added. **Meinecke & Co., Dept. MH, 225 Varick St., New York 14. (Key No. 207)**

Mica Geiger Counter

A new, thin mica, end window radiation detector with long counting life, stability and negligible leakage has recently been announced. Known as Model D31, the counter has a plateau length of 200 to 300 volts with a slope of 3 per cent per hundred volts. **Nuclear Instrument & Chemical Corp., Dept. MH, 223 W. Erie St., Chicago 10. (Key No. 208)**

Beverage Jug

The new 2 gallon all-stainless steel beverage jug is designed for large beverage distribution, for cart requirements or for individual floor requirements. It is equipped with an ice container for cold beverages and is constructed to hold heat or cold for a reasonable length of time. The faucet has a locking device and is designed for fast flow with positive, no-drip shut-off. The jug is of stainless steel throughout except spigot and chromium plated brass cover lock levers. It has a handle for easy carrying and is attractive in appearance. **Landers Frary & Clark, Dept. MH, New Britain, Conn. (Key No. 209)**

Maintenance Hinge

A new maintenance hinge for use on awning windows has been devised to permit painting and cleaning of the top sash from indoors. The hinge is so designed that protection from rain is retained, as in the fixed hinge principle of operation, when the top sash is restored to its operating position. It is easily operated and is designed for use with the Gate City Awning Window. **Gate City Sash & Door Co., Dept. MH, Fort Lauderdale, Fla. (Key No. 210)**

Hearing Aid

The new Telex 200 hearing aid weighs only 3.4 ounces without batteries. Weight is saved through the use of the polystyrene plastic printed circuit. The Telex 200 combines beauty and durability in the silver and aluminum case with an attractive clip designed to reduce clothing noise by holding clothing firmly over the microphone grill to prevent rubbing. Other features include new low drain tubes, the Telemeter battery economiser, Nylon battery insulation and a three positional tone control. **Telex, Inc., Dept. MH, Telex Park, Minneapolis 1, Minn. (Key No. 211)**

Address manufacturers for further information and prices — or use Readers' Service blank on page 224

Laboratory Water Stills

A new design, incorporating many improvements, is offered in the new "Streamliner" model laboratory water still recently announced. Of polished stainless steel, the new stills are constructed in 3 streamlined offset sections with vapor-tight sliding joints which can be taken apart without tools in 10 seconds, thus simplifying cleaning both inside and out. Technical improvements in the operation of the new stills are also offered. All models are suitable for hard water use and operation is continuous and automatic. Electric, gas and steam heated models are available in capacities from 1 to 4 gallons per hour. **Precision Scientific Co., Dept. MH, 3737 W. Cortland St., Chicago 47. (Key No. 212)**

Security Clamp

A small item which can add greatly to patient confidence is being introduced as the Edwards Security Clamp. Made to hold the nurses' call button always within the patient's reach, the Edwards Security Clamp has curved jaws which fit firmly around the cord attached to the call button. It does not pinch the cord as the smooth, rounded teeth, with no jagged edges, hold the cord firmly around the bedpost or clamp it to the bedding in the desired position. Made of stainless steel, the clamp cannot rust and, although small, it should give helpful service. **Edwards and Company, Inc., Dept. MH, Norwalk, Conn. (Key No. 213)**

Refrigerator Odor Eliminator

Food in walk-in and reach-in coolers can be protected against odors with the new small, compact odor absorber called the "Food Saver." Employing activated carbon as a filter, the device removes gases and odors from the refrigerator air, thus preventing food being spoiled by cross odors. The "Food Saver" is simple in design and one unit is said to sweeten up to 1000 cubic feet of air. **W. B. Connor Engineering Corp., Dept. MH, 114 E. 32nd St., New York 16. (Key No. 214)**

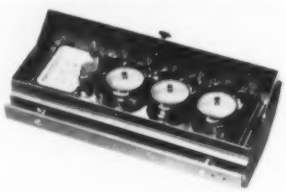
Acoustically-Treated Panels

Fenestra building panels are now available as a complete structural-acoustical unit. The acoustically-treated panels interlock into a flat ceiling as they are laid directly on the beams. Panel ends are welded to the supporting steel structure. The 2 inch sound-absorbing element is elevated from the face of the panels by a wire support. The unit thus gives an acoustical ceiling providing 75 per cent noise reduction which needs only a coat of paint for finishing.

Installed, the acoustically-treated panels are capable of carrying specified loads over design spans and provide a continuous flat surface to support roof insulation or a continuous flat sub-floor to work from that will take a minimum of concrete or other load distributor. The Structural Acoustical Package provides a time and money saving unit for all types of construction. **Detroit Steel Products Co., Dept. MH, 2250 E. Grand Blvd., Detroit 11, Mich. (Key No. 215)**

Infa-Tek Nursery Kit

Designed to safeguard against cross infection, the new Infa-Tek Nursery Kit is all-steel throughout, has a sliding cover and holds containers for everything required in the nursery for infant care. The containers are ceramically marked for gauze, cotton, soap, thermometer, merthiolate, applicators and other needs. The stainless steel tray rack, into which the containers fit, is removable for sterilizing. The Infa-Tek is designed to be



attached to any type bassinet stand and to be used for only one infant at a time, thus removing a possible source of cross infection. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 216)**

Mildew Inhibitor

A new product has been developed for use in the laundry rinse to inhibit the growth of mildew in linens. It may be used on all types of items in the laundry, including white and colored starch work, towels, bed and table linen and uniforms. Known as Biolite, the product is a water soluble fungicide which, when added in small quantity to the rinse, penetrates the fabric fibers and remains until the fabric is re-washed when it is removed by the high alkalinity of the initial sudsing operation. Biolite obviates the necessity for the strong bleach solution used to remove mildew stains, thus increasing the possible life of linens. The product is sold through laundry supply houses and was developed by **Monsanto Chemical Co., Dept. MH, 1700 S. 2nd St., St. Louis 4, Mo. (Key No. 217)**

Pharmaceuticals

Bacidrin

Bacidrin is a lyophilized nasal preparation combining the antibiotic activity of bacitracin and the constrictor activity of ephedrine for the treatment of upper respiratory infections associated with inflammation and congestion of the nasal mucosa. When dissolved in water according to directions it provides a non-irritating, isotonic, buffered solution. Bacidrin is supplied in 15 cc. bottles with droppers. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 218)**

Dihydrostreptomycin Sulfate

Dihydrostreptomycin Sulfate is now commercially available in crystalline form. The new form is said to permit the establishment of higher standards of purity and potency for this antibiotic which is used in the treatment of tuberculosis. **Heyden Chemical Corp., Dept. MH, 393 Seventh Ave., New York 1. (Key No. 219)**

Synkavite—CB Roche

Synkavite-CB Roche is a combination of a water-soluble vitamin K compound with vitamin C and B complex factors in easy to take capsule form. It is indicated in the preoperative and postoperative management of surgical patients, particularly in tonsillectomy, nasal and plastic surgery and in certain major surgical procedures. It is supplied in vials of 20 and 100 capsules and in bottles of 500. **Hoffmann-La Roche Inc., Dept. MH, Nutley 10, N. J. (Key No. 220)**

Milibis

Milibis, which as WIN 1011 was recently announced as "a cure for amebic dysentery," is now being made available. Known chemically as bismuth glycolylarsanilate, the compound has been under clinical investigation in the United States since 1947. It is being offered as a prescription specialty in .25 gram tablets in bottles of 50 and 500 for oral administration. **Winthrop-Stearns Inc., Dept. MH, 170 Varick St., New York 13. (Key No. 221)**

Fungi-Treat

Fungi-Treat is a new fungicidal solution containing Hyamine 3258, a powerful penetrant, in combination with a well-known fungicide, salicylanilide. It is designed to attack directly the fungus growth both on and under the skin surface. It is available in 1 ounce, pint, quart and gallon bottles. **Dome Chemicals Inc., Dept. MH, 109 W. 64th St., New York 23. (Key No. 222)**

Address manufacturers for further information and prices — or use Readers' Service blank on page 224

Methajade Antitussive

Methajade Antitussive is a cough preparation containing the new analgesic compound, methadone hydrochloride, which combines the sedative effect of methadone with expectorant, antispasmodic and soothing ingredients. Containing no sugar, the preparation has a pleasant lime flavor and its palatability makes it readily acceptable to patients of all ages. It is indicated for the relief of coughs of all types and is supplied in 16 fluid ounce and gallon bottles. **Sharp & Dohme, Inc., Dept. MH, 640 N. Broad St., Philadelphia 1, Pa. (Key No. 223)**

Bevidox

Bevidox is the Abbott trade mark for crystalline vitamin B_{12} derived by fermentation process with streptomyces griseus. It is protein-free and chemically identical with vitamin B_{12} originally isolated from liver sources. It is designed for subcutaneous or intramuscular administration in various types of anemias and is supplied in boxes of six 1 cc. size ampules, each cc. containing 15 micrograms of vitamin B_{12}. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 224)**

Furacin Vaginal Suppositories

Furacin Vaginal Suppositories, antibacterial, are designed for the treatment of bacterial cervicitis and vaginitis and for both pre and post-operative use in vaginal and cervical surgery and electrosurgery. Each 3 Gm. suppository contains Furacin (Eaton brand of nitrofurazone N.N.R.) 0.2 per cent dissolved in a water-dispersible, self-emulsifying base which melts at body temperature. The suppositories are supplied in boxes of 12. **Eaton Laboratories, Inc., Dept. MH, Norwich, N. Y. (Key No. 225)**

Water Soluble Vitamins

Three new water soluble vitamin products have recently been announced by Mead Johnson, all especially designed for infants and children. The new products are clear, water-soluble solutions containing the specified vitamins in well balanced amounts. They are rapidly soluble in liquids, palatable and convenient to administer. Ce-Vi-Sol is a vitamin C solution; Tri-Vi-Sol is a solution of three vitamins, A, D and ascorbic acid, and Poly-Vi-Sol is a solution containing vitamins A, D, ascorbic acid and the clinically important members of the vitamin B complex. All are supplied in 15 cc. and 50 cc. bottles, each with dropper. **Mead Johnson & Co., Dept. MH, Evansville 21, Ind. (Key No. 226)**

Product Literature

• Basic information on **"Linde Oxygen Piping Systems for Hospitals"** is contained in a booklet recently issued by The Linde Air Products Co., 30 E. 42nd St., New York 17. Each point in the consideration, planning and operation of a central oxygen system is illustrated and the text covers the subject in a factual yet interesting manner, presenting helpful data. Subjects covered include Oxygen Piping Systems Cut Costs, Advantages of a Piping System, the Central Oxygen Supply, the Piping System, Oxygen Station Outlet Location and Specifications for Installation of Oxygen Piping Systems in Hospitals. **(Key No. 227)**

• A small but important leaflet entitled **"Introducing Your Hospital Dietitian"** has recently been made available by the Consumer Service Dept., General Baking Co., 420 Lexington Ave., New York 17. The leaflet, designed for distribution to hospital patients to help them understand the dietitian and her problems, should also be of interest to hospital administrators and department heads. The leaflet discusses such subjects as, who is your hospital dietitian, what does she do, what is her training, how her work affects you and how you can help her. **(Key No. 228)**

• **Kayline Catalog No. 50** covers the full range of fluorescent, incandescent and slimline lighting developed by The Kayline Co., 2480J E. 22nd St., Cleveland 15, Ohio. Each type of lighting is described and illustrated with room indexes, cross section diagrams, mounting instructions, distribution curves and specifications. **(Key No. 229)**

• The story of **"Blue Ridge Aklo Glass,"** a glass which filters daylight by barring rays that tire the eyes and carry heat, is told in a booklet issued by Libbey-Owens-Ford Glass Co., Nicholas Bldg., Toledo 3, Ohio. The glass is described as being a soft, eye-rest blue-green in color and its use is said to lower costs of air-conditioning, reduce glare and increase personnel efficiency. **(Key No. 230)**

• A new publication, devoted exclusively to the use of modern electro-optical instruments, including their use in medical research and routine analysis, has recently been announced by The Perkin-Elmer Corp., Glenbrook, Conn., Volume 1, Number 1 being the Autumn 1949 issue. Known as the **Perkin-Elmer Instrument News**, the publication will appear quarterly. **(Key No. 231)**

• A new catalog has been issued by Supreme Steel Products Inc., 52-55 74th St., Maspeth, L. I., N. Y., covering their full line of **"Lockers, Shelving, Cabinets."** Full descriptive information is augmented by illustrations. **(Key No. 232)**

• **"The Story of Sundries"** is the title of a 24 page booklet issued by the B. F. Goodrich Company, Akron, Ohio, which, in addition to describing and illustrating the items in their sundry line, gives a brief history of rubber, the development of Koroseal and some of the more graphic steps in manufacturing. Two editions of the booklet are available, one covering B. F. Goodrich sundries and the other featuring Miller sundries. **(Key No. 233)**

• Information on **"The Hollister Planned Goodwill Program"** appeared in our Product Literature columns in the January issue of The Modern Hospital. In that item we neglected to give the name and address of the company that created this effective public relations program material and is supplying it to hospitals that use the Hollister Goodwill Builders —the attractive and effective Hollister Birth Certificates, Hollister Footprint Kits, Seal-Impressing Service and Special Long-Reach Seal Press and the recently announced Hollister Certificettes. All of these were developed and are offered by Franklin C. Hollister Co., 833 N. Orleans St., Chicago 10. **(Key No. 234)**

• **Fisher Unitized Laboratory Furniture,** designed to be easily and quickly installed either as single units or as complete laboratory arrangements, is described and illustrated in **Catalog B** recently issued by Fisher Scientific Co.-Eimer and Amend, 717 Forbes St., Pittsburgh 19, Pa. The 18 standard pieces of furniture which compose the line are illustrated as single units and as they are used in typical assemblies in various laboratories. Two pages of sketches illustrate typical furniture assemblies for various laboratory requirements. **Key No. 235)**

• **Technical Bulletin No. 2** on centralized panel program control systems for hot water and radiant heating has recently been issued by Sarcotherm Controls, Inc., Empire State Bldg., New York 1. Schematic diagrams of boiler hookups and wiring diagrams are included, together with complete specifications for these systems. **(Key No. 236)**

• **"Maintenance Checking Chart"** is the title of a publication recently released by United Laboratories, Inc., 16801 Euclid Ave., Cleveland 12, Ohio. The chart is designed to assist those responsible for plant and building maintenance in securing needed products and services. **(Key No. 237)**

• A completely new 32 page catalog covering the entire Stokes line of **pharmaceutical equipment and auxiliaries** has been published by the F. J. Stokes Machine Co., 5900 Tabor Rd., Philadelphia 20, Pa. **(Key No. 238)**

Address manufacturers for further information and prices — or use Readers' Service blank on page 224

• A series of attractive booklets has been issued by International Business Machines Corp., 590 Madison Ave., New York 22, giving full data on their new line of equipment. Included are booklets on the following new IBM machines and services: Cardatype, accounting machine, card-programmed electronic calulator, electronic statistical machine, card punch, alphabetical collator, consecutive spacing time recorder, executive typewriter, service bureau, inventory control and market research analysis. A special booklet, **"IBM Service,"** gives information on the company, its research, education, production, products, sales and systems service, special departments and customer service. **(Key No. 239)**

• Packaged air conditioners for a wide variety of applications are described in a series of bulletins issued by the Air Conditioning Dept. General Electric Co., Bloomfield, N. J. Each of the bulletins describes and pictures the units and gives specifications, ratings and dimensions. These bulletins on the **"Packaged Air Conditioner"** cover sizes from small installations to those for large institutions. **(Key No. 240)**

• **"How to Clean and Maintain Air Conditioning and Refrigerating Equipment at Less Cost"** is the challenging title of a 20 page booklet recently published by Oakite Products, Inc., 22 Thames St., New York 6. Latest equipment-cleaning and descaling procedures, as well as simplified water-treatment technics for controlling slime, algae and scale, together with data on specific materials and methods which have demonstrated the ability to secure improved results are discussed in the booklet. **(Key No. 241)**

• Four basic types of coal handling and storage systems, which feature simplified design, engineering, erection and low initial and ultimate cost, are described in the new **Bulletin No. 300,** giving 14 case histories, issued by Gifford-Wood Co., Hudson, N. Y. **(Key No. 242)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of The MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

Bessie Covert
Editor, "What's New for Hospitals"

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Book Announcements

The Commonwealth Fund, 41 E. 57th St., New York 22. Corwin, "Ecology of Health," 196 pp., $2.50. **(Key No. 243)**

Lea & Febiger, Washington Square, Philadelphia 6, Pa. Kovacs, "A Manual of Physical Therapy," 328 pp., $3.75. **(Key No. 244)**

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Berens, "The Eye and Its Diseases," by 92 International Authorities, 2nd ed., 1092 pp., $16. Christopher, "Christopher's Textbook of Surgery," by 198 American Authorities, 1550 pp., $13. Newburgh, "Physiology of Heat Regulation and The Science of Clothing," 457 pp., $7.50. Orr, "Operations of General Surgery," 2nd ed., 890 pp., $13.50. Wells, "Clinical Pathology," 397 pp., $6. Wolff, "Electrocardiography," 187 pp., $4.50. **(Key No. 245)**

Standard Scientific Supply Corp., 34 W. 4th St., New York 12. Fister, "Manual of Standardized Procedures for Spectrophotometric Chemistry," over 500 pp., $31. **(Key No. 246)**

Suppliers' News

Nathan Straus-Duparquet, Inc., 33 E. 17th St., New York 2, hospital equipment supplier, announces its appointment as exclusive national distributor for the British manufactured Columbus Floor Maintenance Machines which are designed for full maintenance of all types of floors.

North Star Woolen Mill Co., Minneapolis, Minn., manufacturer of North Star woolen blankets for the past 85 years, has moved its corporate and manufacturing headquarters to **Lima, Ohio.**

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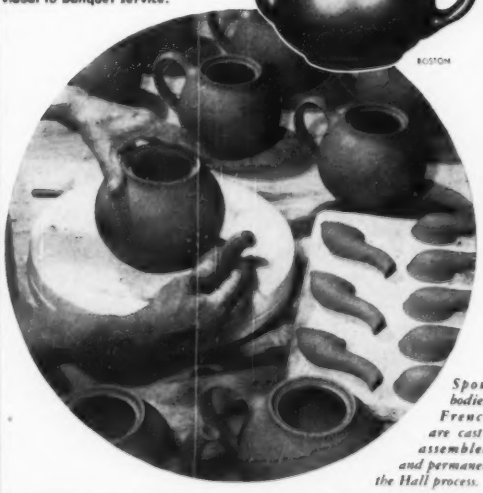

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